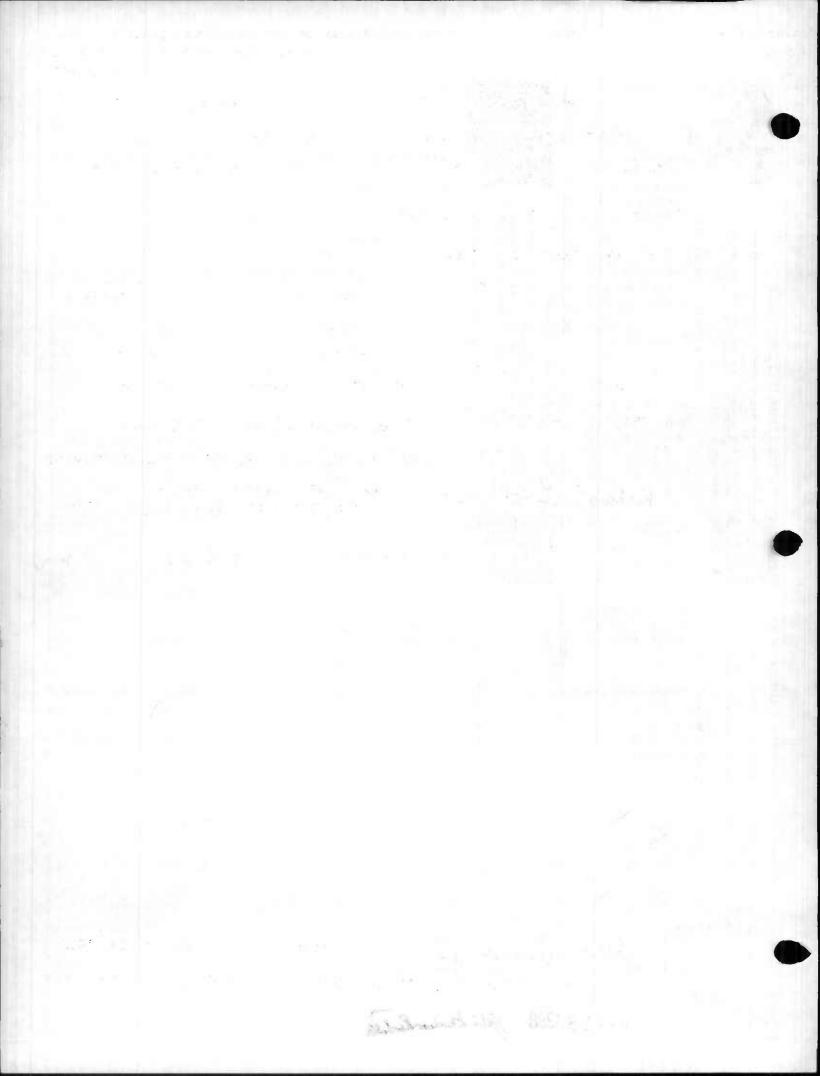
State of Maryland / Department of Health and Mental Hygiene 2 501

					Cer	tificate	of L	Death		F	leg. No.	UZ	301	
Physici		Decedant's Neme (First, Middle, L Eerth	.,	GROVE						2. Dete of Dee January	7 124, 19	9 38 .	3. Time of D 5:50	
/Medio Examir		4a. Fecility Name (If not institution, gi	ve street and number) Creek Drive	e, Apt	. 1			o. city, Tov Frede		cation of Deeth	,	of Deeth	k	
Funeral Director		216-46-1936	Sex 7. Age	(In yrs. last I	birthdey) Yrs.	If Under 1 Months	Year Deys	If Under 2 Hours	24 Hrs. Min.	8. Dete of Birth (Month, Dey November	29,1908	9. Birthp Coun Mary	lace (Stete or I	Forei
within 72 hours eiter deeth with the Marylend ene. "hatural", or items 23a or 28a-f show the Medical Examiner mast be notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Freder	ick	10c. City, To								1	0d. Inside City	
3a or 28a at be null	Funeral Director	10e. Street end Number 1616 Rock Cree	k Drive, Ap	ot. 1	H	10f. Zip C	oda 170	2		1	U.S.A		itry?	
al, or items 23a or 28a-f show	b	11. Maritel Status 1 ☐ Never Married 2 ☐ Married 3 ∰Widowed 4 ☐ Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Yeer or Detes:	ever in U,S.		Wes Deceder f Yes, specify		spanic Origin, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		ce - Americ ck, White, v: Whi	etc.	
iene. · than *natural', rie Medical Exe	Completed	15. Decedent's E (Specify only highest gi Elamentary/Secondary (0-12)	ducetion rade completed) Collega (1-4or 5-		(Give	lent's Usuel (kind of work DO NOT usa Homem	done di ratired)	uring most	of working	ng	16b. Kind of B	usiness/ind		
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of Health end Mer item 27 is marke other traumatic		19a. Informent's Neme/Reletionship Mr. William Jark 20a. Method of Disposition	(~	Jr.	812 L	ong Cre	sœn	t Road		stol, Vii	r, City or Town,	201		
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Depa impor any ir		PRICHAGE	MI	00255	T	Zaanar	one	d Poo	ford	P.A. Fred	uneral lerick,	Home Md 2	1701 Approximate	
nysician Medical Medical sa speciar oud sa speciar oud sa speciar oud sa speciar sa spec	iner	Immadiata Cause (Final disease or condition resulting in deeth)	· Carci		6	Colm							Intervel Betwee	ath
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within 24 hours effer de To the Funeral Directo completely filled in by th	29a. Certifilar (Check only one) Certifying Physician: To the best of my knowledga, of the basis of axamination end/of and manner steled.				ga, death end/or inv	, death occurred at the time, data and place,				nd dua to tha c	ause(s) and ma	annar as si end due to	ir as statad. due to the ceuse(s)	
within To the comple	Mex	29b. Signeture end title of certifier Outin 30. Nama and addrass of person who	Born	2-) (Type, I	D	License	number		2	29d. Date signe January			
Sta Registra	ar	30. Nama and addrass of person who Dr. A. Aust: 31. Dete filed (Month, Day, Year)	in Pearre,	Jr., 3	300 W	Print) Vest N:			eet,	Freder	ick, Ma	ırylaı	nd 2170)

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 8

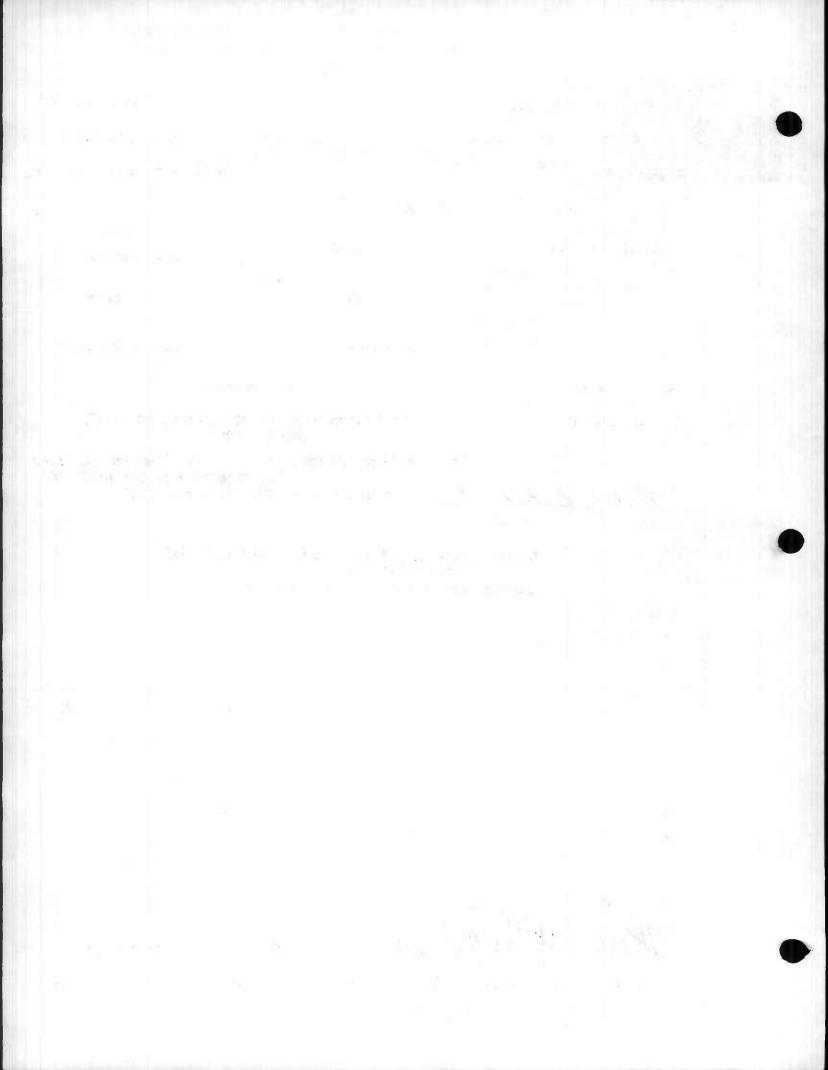
					Cer	uncare	of Death		Re	g. No.	0 64	
Dhysioi	an	1. Decedent's Neme (First, Middle	, Last)						te of Deeth			3. Time of Death
Physici /Medic		IDA NELLI						Jan	uary	6, 199	8	8:30 AM
Examin	ner	4a. Fecility Name (If not institution		ber)				own, or Location	of Deeth	4c. County	of Deeth	
		Citizens Nur				If I lades 1		derick			derick	
Funeral Director		5. Social Security Number 213-18-8165 Usual Residence of Decedent	6. Sex 1 M 2 F	Age (In yrs	(lest birthday) Yrs.	If Under 1	Days Hours	Min. Sep.	te of Birth onth, Dey t. 15	, 1904	9. Birthplace Country) Mary.	e (Stete or Foreig Land
a or 28a-f show the notified at		10a. State 10b. County		10c. C	ity, Town or Loc	cation					10d.	Inside City Limits
28a-f eh	ţō	Maryland Fred	erick		Frederi	ob						XXYes 2□ No
or 28a-f	irec	10e. Street end Number			ricaebe	10f. Zip Ci	ode		10	g. Citizen of V	Vhet Country	?
23a c	al D	23 West All S	aints Stra	ot		21	702			United	State	S
at', or items	by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Vidowed 4 Divorced	12. Wes Deced Armed Force ed 1 Tyes 2 If Yes, Give Yeer or Dat	es? No		Vas Deceder Yes, specify	nt of Hispenic Ori Cuban, Mexican No Specify:		es or No- etc.)		e - American sk, White, etc.	Indian, ack
ical i	te d	15. Decedent	's Education		16a. Deced	ent's Usuei (Occupation		1	6b. Kind of Bu	isiness/Indus	try
Mad .	To Be Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4	4or 5+)	life. D	OO NOT use	done during mos retired)	st of working				
or the	Son	6th				Homema	iker			OWI	1	
Theath and Mental Hygi item 27 is marked other other traumatic event, I	Be	17. Father's Name (First, Middle, I					18. Moth	er's Name (First,	Middle, M	leiden Sumem	e)	
merked metic e	2	William A. Do					Ma	linda E	. Tho	mas		
27 is m r traum		19e. Informant's Name/Reletionsh Jeffrey D. Scot					Street end Numb					
Department of Haz Important: If item any injury or othe once		20e. Method of Disposition 1 Days 2 Cremation 4 Donetion 5 Other (Sp. 21. Signature of Funeral Service I	ecify)		airview 22.	Cemet Name and	CCLY Address of Facili	1/9/	98 er Fu	Freder neral t	ick, Mi Homes,	and 2115 State aryland P.A.
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/ledical aminer		Immediate Ceuse (Finel disease or condition	100	7	1-3							
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State of Maryland / Department of Health and Mental Hygiene

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al', or items	by Funeral Director		s erried Married d 4 Divorced	12. Wes Decede Armed Force 1 Tyes 2 If Yes, Give Yeer or Date	es? No		Wes Decede	ent of Hispanic Origin? by Cuben, Mexican, Pu No Specify:	(Specify Yes or Nerto Rican, etc.)	o- 14. Race Blec	e - American Indian, sk, White, etc.	
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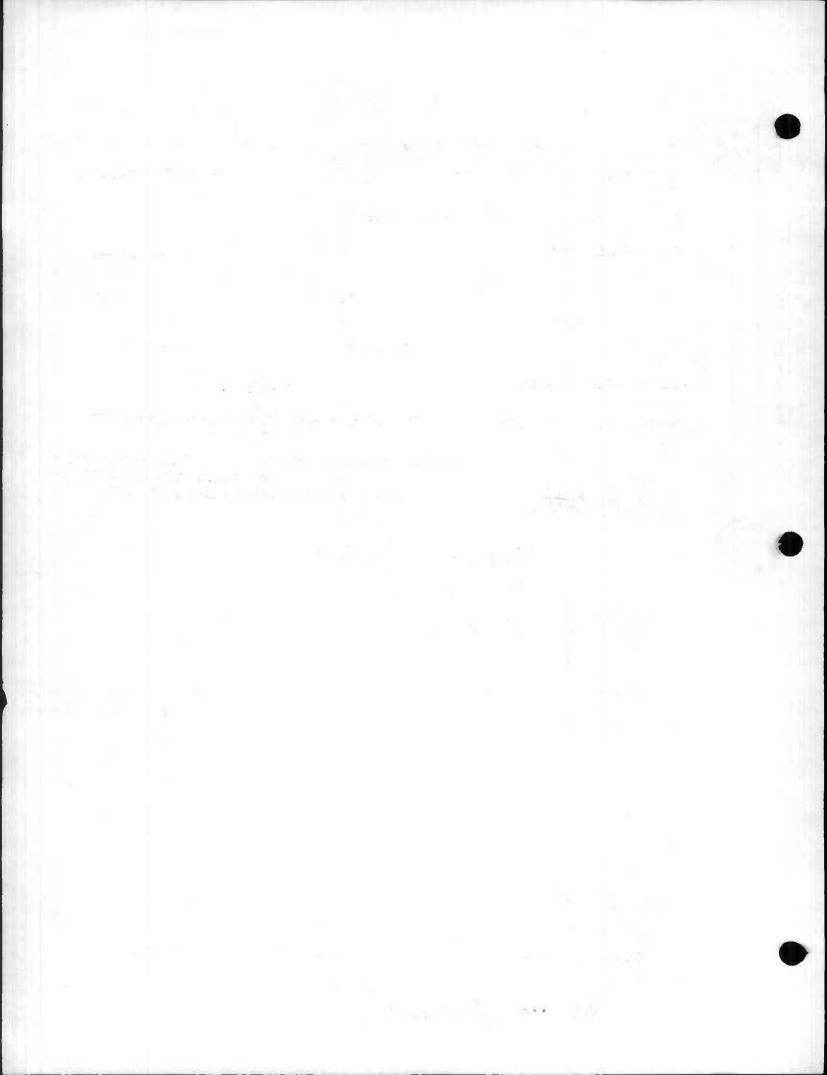


State of Maryland / Department of Health and Mental Hygiene 02504 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month month 4c. County of Deeth ·OIA.M mmoni /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Dey, Georges 5. Sociel Security Number 7. Age (In yrs. last birthdey) If Under 1 Year Birthplece (State or Foreign Country) **Funeral** Months Days 76 Feb 2, Director Nebraska 12 1077 536 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Modical Examinat must be notified at 1 Yes 2 No Director MD P.G. Upper Marlboro 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20772 4708 Melwood Road "natural", or items 23a United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, its Medical Exempted 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes XX No Specify: by Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be George McKinley Brown Stella Miner 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 4708 Melwood Road, Upper Marlboro, Md 20772 Marshall F. Hammond , Jr, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)

21 , 22 | 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from State Cheltenham, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cemetery 21. Signeture of Funeral Servica Licansee 22. Name end Address of Fecility ee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediete Cause (Final diseese or condition resulting in deeth) /Medical Juni **Examiner** Due to (or es e consequenca of) Physician/Medical Examiner Diverticulosis attending physician and for use es the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequenca of). Box 68760, nutrition AL thet initieted events resulting in deeth) Lest Due to (or es e consequence of): The law requires that the death Records, P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. the 23b. Dfd tobecco uee contribute to the cause of death? detached signed by to 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed peen 24a. Wes en eutopsy has certificate 1 ☐ Yes 2 No 1 ☐ Yes 200 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Minpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2V No 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? Certification: 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide Medical 29a. Certifier 🖫 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name end address of person who completed cause of eeth (Item 23e) (Type, Print) esley Jr Mo 2700 old Brand Ave Clinton and 20735

State Registrar



State of Maryland /

Department of Health and Mental	Hygien
Certificate of Death	Reg. N

02505

29d. Date signed (Month, Day, Year)

JANUARY 18, 1998

Physician	
/Medical	
Examiner	I

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examine must be notified at 90ce.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Midd	lle, Last)							2. Date of De				3. Time of Death
Daniel Aller	Hammers	1a						JANUAR'		7, 19	Year 998	1407PM
4a Facility Name (If not institution						4b. City,	Town, or L	ocation of Deat	h i	c. County	of Deeth	
SOUTHERN MARYL	AND HOSDI	ייאד בי ב				CLIN	MON		P	RINCE	E GEO	RCFS
5. Social Security Number	6. Sex		last birthday)		ar 1 Yaa	ar If Und	lar 24 Hrs.	8. Date of Bir			9. Birtho	olaca (Stata or Foraig
217-82-2579	1 X M 2□ F	38	Yrs.	Months	s Day	s Hour	s Min.	8. Date of Bir (Month, Da NOV 21	Y Yes	29	Coun	ntry)
Usuel Residence of Decedent		30						1101 21		33	Mal	yland
10a. State 10b. County	/	10c. C	ity, Town or Lo	cation							1	Od. Insida City Limits
37/2			27 61									1 Yas 2 No
	ked addre	SS	No fix									
10e. Street and Number				101. 2	ip Code	9			10g. (What Cour	ntry?
No fixed address	SS						N,	/A		U	JSA	
11. Marital Status	12. Was De Armed I	cedent Ever in U	J,S. 13.	Was Dec	edent o	f Hispanic	Origin? (Spen, Puert	pecify Yes or No o Ricen, etc.))-		ck, White,	ean Indian,
X ☐ Never Married 2 ☐ Mar	rled 1 ☐ Yes	2 No		1 🗆 Yes	**						TaTle :	ite
3 ☐ Widowed 4 ☐ Divorces	if Yes, C	Detes:		1 1 1 1 1 1 1 1 1	2 6.9 14	io speci	ıy.			Specify	y: ****	200
15. Deceder	nt's Educetion		16a. Dece	dent's Us	ual Occ	upation		4.	16b.	Kind of B	usiness/în	dustry
	st grade completed	-	16a. Dece (Give life.	DO NOT	usa reti	ne dunng m ir e d)	ost of wor	King				
Elementery/Secondary (0-12)	College	(1-4or 5+)	Pai	inter	an	d Dry	Wal:	Mec.	C	onstr	ructio	on
17. Father's Nama (First, Middle,	Last)							ne (First, Middle	_			
								ia E. Jo				
Donald L. Hamr												
19a, Informant's Name/Relation								ral Route Numb				Code)
Donald L. Hamme	ersla (Fa					Road	White	Plains	5, 1	MD 20	695	
20a. Method of Disposition			Place of Dispo cametery, cree	sition (N	ame of	olace)		Date	20c.	Location -	- City or To	own, State
1 Burial 2 Cremation 4 Donation 5 Other (5		n State	tropoli				v 1+	21-98	Ale	exand	ria,	VA
			*				-					
21. Signature of Furieral Service	Licensee	M001	73	Г.Н.	Ebe	ress of Fe	Mor	-				
21. Signature of Furieral Service Charles Service 23a. Party. Enter the disease, o shock, or heart failure. Lis	Complications that	caused the dea	73	Г.Н. 1433	Ebe	rwein	Mor	White I	P1s	., MI	2069	95 Approximate Interval Betwaen Onset and Death
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State Registrar

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31. Date filed (Month, Day, Year) JAN 2 1 1998

29b. Signature and title of certifier

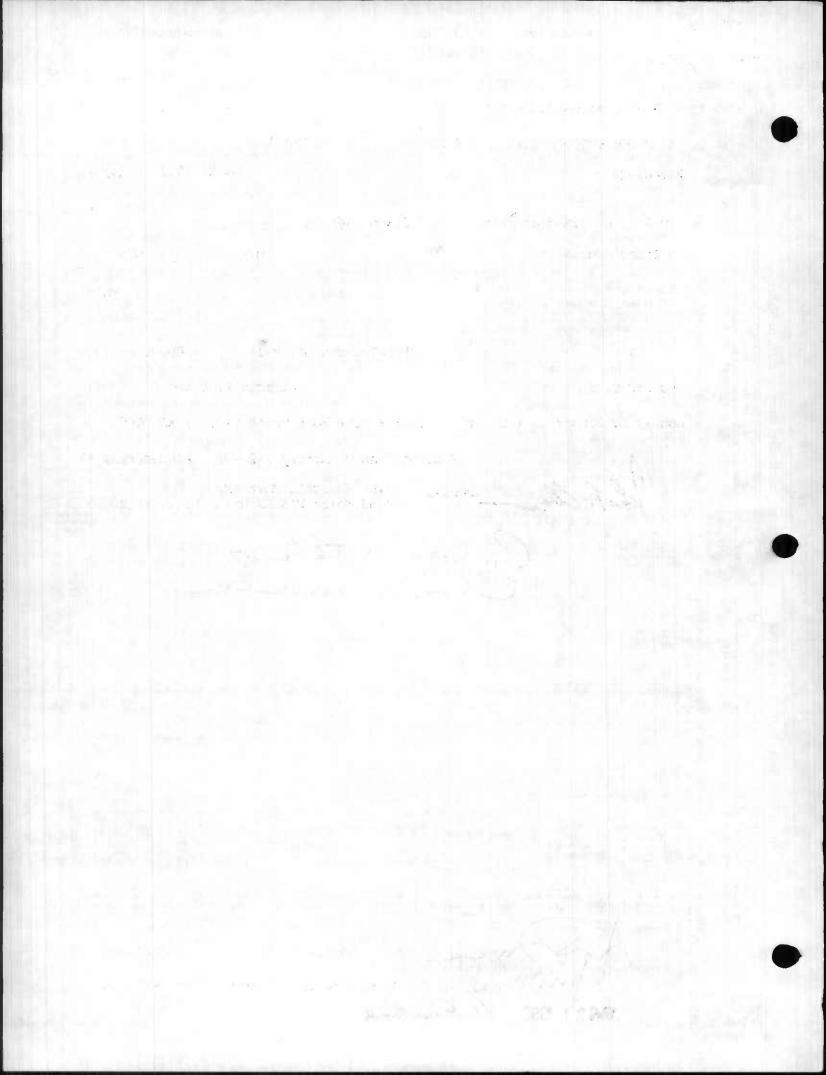
32. Registrar's Signature

death (Item 23a) (Type, Print)

29c. License number

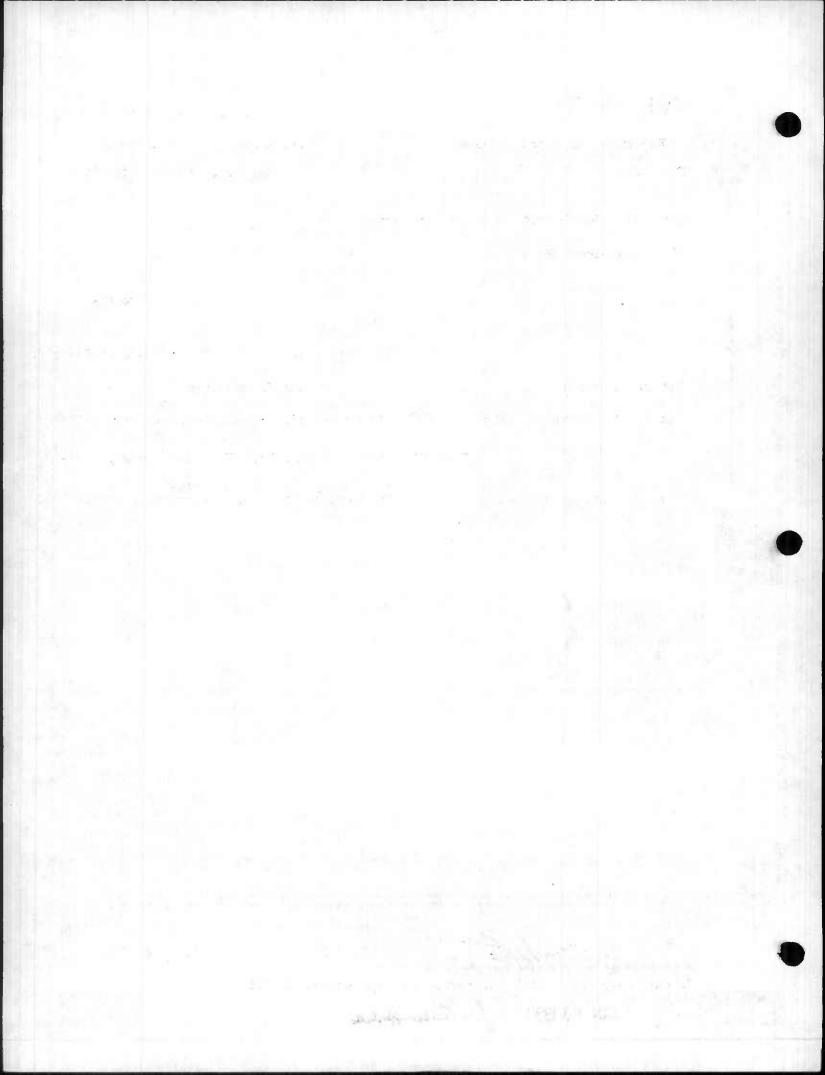
O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Cei	rtificat	e of	Death		Reg. No.	02	505
hysiciai /Medica		1. Decedent's Name (First, Middle, HAZEL POOLE HAY							2. Dete of De Month	Dey	Yeer 998	3. Time of Deeth
xamine		4e. Fecility Neme (If not institution, g					4	tb. City, Town, or Hagerst		4c. County		12:10 AM
neral ector					. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Birt	, 1924	9. Birthpled Country Mary	e (Stete or Foreign Land
at at		10a. Stete 10b. County			ity, Town or Lo						10d	. Inside City Limits
notffled		Maryland Washin	ngton	Ha	gersto	VIII	Codo			40- 67		1 ☐ Yes 2♥ No
		17703 Woodcrest	Road				1740			U.S.A.	wnet Country	7
	ny ru	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed - 4 □ Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	ces? 2 X No		Vas Deced f Yes, spec		ispenic Origin? (S in, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	- 14. Rec Bled	e - American ck, White, etc	
it, the Medical Ex	blered	15. Decedent's (Specify only highest of Elementary/Secondery (0-12)	Education grede completed) College (1	Aor Su)	16e. Deced (Give life. L	lent's Usue kind of wor DO NOT us	el Occupi rk done d se retired	etion during most of wo	rking	16b. Kind of Bu		
t Ene la	5		5 +		Guidar	nce C	ouns	elor		County F	Ed. of	Fraucation
umatic evant, in		17. Fether's Neme (First, Middle, La Arthur L. Poole	st)						me (First, Middle,		10)	
T	-	19a. Informent's Name/Relationship	(Type, Print)		19b. Mailin	a Address		Rhoda M. and Number or Ri			State 7in C	ode l
or trac		Clayton A. Hayes		ıd	17703	Wood	cres	t Rd. H	agerstov	m, Mary	land	21740
ing injury or other traumatic event, the Mance.	1	20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec		late	Plece of Dispo cemetery, cren e Hill			Jan. 19	Date , 1998	20c. Location -		
any injugace.		21. Signature of Funeral Service Lic	ensee Ain		22 I	Name en	d Addres	ss of Fecility Fiery				land 21742
Wedical Examiner		immediate Ceuse (Finel disease or condition resulting In death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest		Due to (NSON D	CT INFE or es e consequences e conse	with uence of):		TH SEPSIS	5		MA	days NY ARS
		2 de la Colonna de Maria de La Colonna de La	d									
be detached for us.		Pert II. Other elgnificent conditions	contributing to de	eth but not res	sulting in the ur	derlying ca	ause give	en in Pert I.				e cause of death?
2 should										en eutopsy rmed?	evelle	eutopsy findings ble prior to letion of cause oth?
rector, page		or Mar								es 200 No	1 🗆 Y	es 2 No
		25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☑ No	Hospital:	pationt 2	ER/Outpetient	2□ 00	Othe	AP.	th (Check only o		(0 1/1)	
- I U				Injury , Dey Year)	28b. Time of Injury	-	Bc. Injury Work		ome 5 Resid	ow Injury occurr		
uneral di	-	7. Menner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident Investigati										
in by the funeral di	2	1 Maturel 5 ☐ Pending	be 28e. Place of	of Injury - At h g, etc. <i>(Specil</i>	ome, ferm, stre	et, fectory,	, office		28f. Location (S City or Tow	itreet and Numbern, Stete)	er or Rural R	oute Number,
tely filled in by the funeral di	2	1 Maturel 2 Accident 3 Suicide 4 Homlcide 29a. Certifier 1 Certifying P	be 28e. Place of	est of my kno	y) wledge, death	occurred e	at the tim	e, dete end place inion, deeth occu	City or Tow	n, Stete)	nner es etete	d
in by the funeral di	2	1 Maturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 29 Medical Exa	28e. Place of building	est of my kno	y) wledge, death	occurred e	at the tim	inion, deeth occu	city or Tow , and due to the c red et the time, c	n, Stete)	nner es state and due to the	d. e cause(s)
tely filled in by the funeral di	2	1 Maturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 19b. Signeture end little of certifier	28e. Place of building thysician: To the basend menner.	est of my kno less of examina er steted.	y) wledge, death tion end/or inv	occurred e estigation, 29c.	et the tim In my op	number	city or Tow , and due to the c red et the time, c	n, Stete) eause(s) end medate end piece, a	nner es state and due to the	d. e cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3 Time of Death Month Betty Havens-Randle January 8 1998 12:05 AM 4b. City. Town, or Location of Death 4a. Facility Nama (If not institution, give street and number) 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 1□M 2□F Yrs. 56 216-38-0354 Feb. 13, 1941 Maryland Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Thurmont X Yes 2 □ No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 302 East Main Street 21788 U. S. A. 12. Was Decedant Evar In U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas → No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married

1 Yas 32√ No Specify:

16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired)

22. Nama and Addrass of Facility

Physician /Medicai Examiner

Department of important: if any injury or once.

Physician

/Medical

Examiner

10a. Stata

12

3 ☐ Widowed 4 ☐ Divorced

Elementery/Secondary (0-12)

17. Fathar's Nama (First, Middla, Last)

19a. Informant's Name/Ralationship (Type, Print)

Van C. Randle - husband

4 ☐ Donation 5 ☐ Othar (Specify)

21 Signature of Fundal Sarvice License

Burial 2 Cremation 3 Ramoval from Stata

Reno W. Linton

20a. Mathod of Disposition

Immediata Causa (Final disaasa or condition resulting in death)

Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated avents rasulting in daath) Last

25. Wes casa rafarred to medical axaminar?

1 Yas 2 No

27. Manner of Deeth

1 1 Natural

2 Accidant

4 ☐ Homicida

(Check only one)

3 ☐ Suicida

29a. Certifier

15. Decedent's Education (Spacify only highast grada complated)

Funeral

Director

"natural", or items 23s or 28s-f show

al Hygiene.
d other than "natural"

Pages 1 and 2 should be file ment of Health end Mental Hy ant: if hem 27 is marked oth lary or other traumatic event

Director

Funeral

by

Completed

Be

filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0020

Physician/Medical Examiner sician and buriel-transit The law requires that the death certificate be executed physician s the burie as for use signed by the a þ Completed page 2 or Attending Physician: Be Certification: To this funeral Aftar deeth. efter deeth Director: 24 hours efter Funeral Dire pletaly filled in b

Box 68760, P.O. Division of Vital Records.

> State Registrar

Medicai

31. Data filad (Month, Day, Year)

5 Panding

Invastigation

6 Could not be determined

32. Ragistrar's Signatura Devilear Rantall

Sepsis

Collaga (1-4or 5+)

Dua to (or as a consequence of)

23a Part 1. Enter the disease of complications that caused the death too not antar the mode of dying, such as cardiac or respiratory arrest, shock, a heart tollure. List only one cause on each line.

Cashier

20b. Placa of Disposition (Neme of camatary, cramatory or other place)

BronchiTIS

Dua to (or as a consequence of):

Dua to (or as a consaquance of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMA

Dinberts Mell, TUS

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were eutopsy findings available prior to complation of causa of death?

3 Probably 4 Unknown

white

21788

Approximata Interval Between Onsat and Death

21702

16b. Kind of Business/Industry

20c. Location - City or Town, Stata

23b. Did tobacco usa contribute to the cause of death?

Grocery

18. Mothar's Nama (First, Middla, Maidan Sumama)

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Coda)

Resthaven Memorial Gardens 1-12-98 Frederick, Maryland

1621 Opossumtown Pike, Frederick, Maryland

302 East Main Street, Thurmont, Maryland

Margaret V. Snook

Stauffer Funeral Home

1 Yas 2 No

1 ☐ Yas 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 (Inpatiant 2 □ ER/Outpatient 3 □ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify)

28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work?

1 ☐ Yas 2 ☐ No 28f. Location (Streat and Number or Rural Route Number, City or Town, Steta) 28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Spacify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.
2 Madical Examiner: On the basis of axemination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar

29c. License number D35102

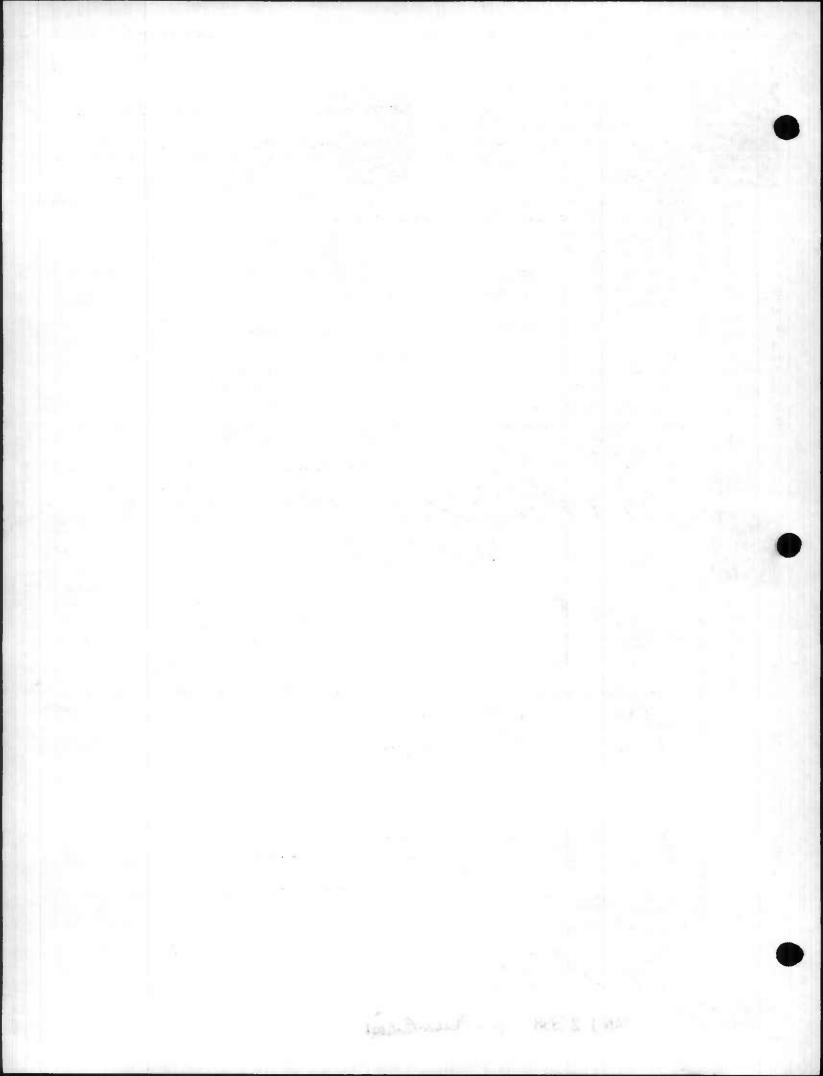
30. Name end addrass of person who completed cause of death (Itam 23a) (Type, Print) . 2

KRINTZ MO

100 S. Center St Thurmon, MD 21788

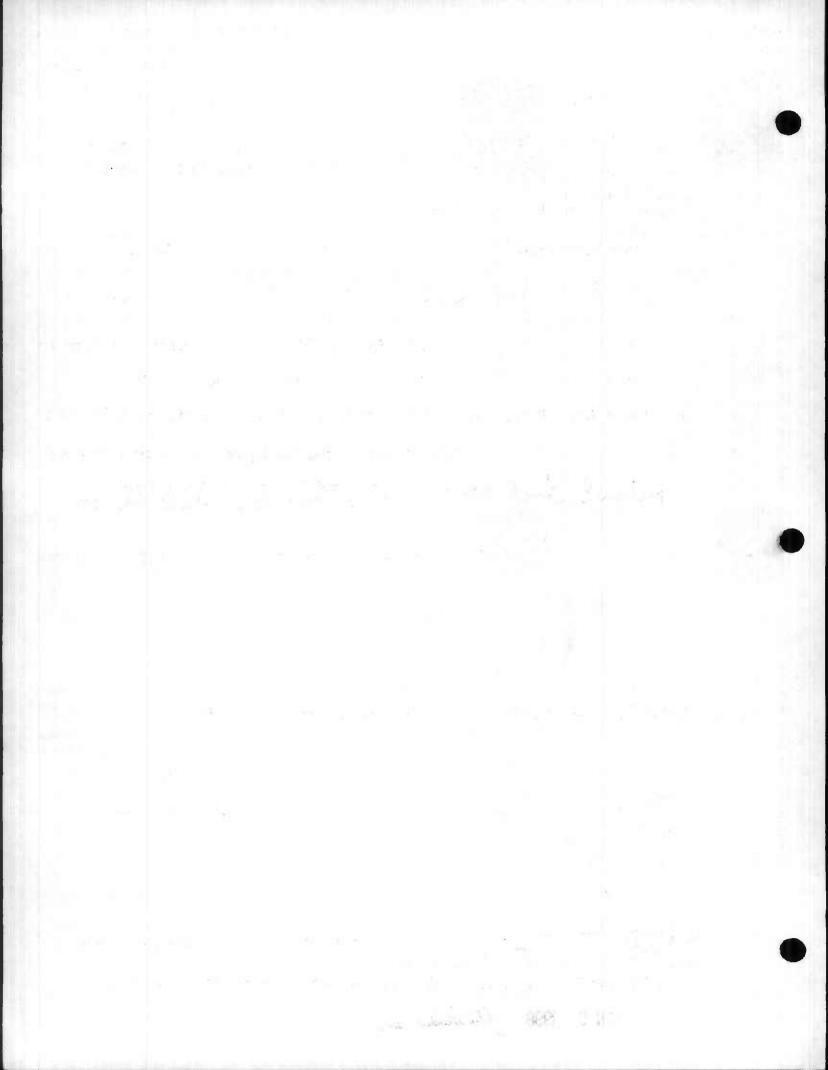
DHMH 16 Rev 6/95

To the Hosp within 24 ho To the Fune completaly fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physic	ian	1. Decedent's Name (First, Middle, La Charles	David HORN		Certificate of		2. Date of De Januar		3. Time of
/Medi	ical	4a. Facility Name (If not institution, give				4b. City, Town, or			
Exami	ner	7033 Rock Cre							
Funeral Director		5. Social Sacurity Number 6. 9 214-32-4106		yrs. last birth Y	Months Dave	r If Under 24 Hrs	erick 8. Date of Bi (Month, D) April	19,1933	ederick 9. Birthplaca <i>(State</i> o <i>Country)</i> Mary Land
of show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederi		. city, Town rederi					10d. Insida Cil 1 ☐ Yes
23a or 28a	al Director	10e. Street and Number 7033 Rock Creek	Drive		10f. Zip Code	21702		10g. Citizan of V	
Hygiene. ther than "natural", or frems 23s or 28s-f show ent, the Medical Exertiner mant be notified at	by Funeral	11. Marital Status 1 Nevar Married 3 Widowed 4 Divorced	12. Was Decedent Ever of Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1952		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No.		Specify Yas or Note Rican, etc.)		e - American Indien, ck, White, etc.
- natur	eted	15. Decedent's E (Specify only highest gra	ducation	16a. C	Decedent's Usual Occu	upation	ndkina		usiness/industry
r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work donuite. DO NOT use retire. 21f Employe			Electr	ical Contra
ev od	Be	17. Fether's Name (First, Middle, Last) Emest)		ORN		me (First, Middle	, Maiden Surnam SHEIS	na)
thend 7 is m traum	To	19a. Informant's Name/Relationship (Mts. Thelma Grace		19b. I	Walling Address (Street	et and Number or R	ural Route Numb	er, City or Town,	
nent of Health int: If item 27 iry or other tr		20a. Method of Disposition **Description** 4 □ Donation 5 □ Other (Specification 5 □ Other (Specification)* **Description**	Ramovai from State	cemetary,	Disposition (Name of crematory or other place) k Memorial P	ace) Park, Jan.	Date 12, 1998		City or Town, State
Departmen Important: any injury once.		21. Signature of Funeral Service Licer Purchase 23a. Part1. Enter the diseasa, or com shock, or heart feilure. List only	N N	55	22. Name and Addi	nd Bacton	ed P.A.	Funeral	Home
ng physician and es the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Indarlying Ceuse (Disease or Injury that Initiated events resulting in death) Last	c		nsequence of):				
ttendir or use	lan/		d						
es been signed by the attendin 22 should be deteched for use	y Physic	Part II. Other algnificant conditions of						tobacco use con	ntribute to the cause of
2 5	Completed by Physician/N							an autopsy ormed?	24b. Were autopsy fi available prior to completion of co of death?
pe ete	Con						10	Yes 2 No	1 Yes 2
s certific director,	Be	25. Was case referred to medical examiner?	Hospitai:		0	thon	ath (Check only		
2 5	. To	1 ☐ Yas 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2	2☐ ER/Outp 28b. Tin	atient 3LI DOA	4 Li Nuising I	1	dence 6 Oth	
O O	tlor	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	(Month, Day Year	r) Inju	M 1	Yes 2□No			er or Rural Route Numi
O w	tifica		building, etc. (Sp.		leath occurred at the	time, date and place	City or To		nner es stated.
fer death. Irector: After this n by the funeral di	cal Certification:	29a. Certifier 1 Certifying Ph	ysicien: To the best of my	knowledge, o	reall occurred at the t	anial are the place	4	4-4-	- 4 4 - 1 - 2
fer death. Irector: After this n by the funeral di	edical	one) 2 Medical Exam	ysicien: To the best of my niner: On the basis of exam and manner stated.	knowledge, o Ination and/	or investigation, in my	opinion, death occi	urred at the time,	date and place,	and due to the cause(s)
fer death. Irector: After this n by the funeral di		Check only 2 Medical Exam	niner: On the basis of exam	knowledge, c	or investigation, in my 29c. Lican	opinion, death occurse number 4626	urred at the time,	date and place, a	and due to the cause(s) d (Month, Day, Year) 7 8, 1998
O w	edical	one) 2 Medical Exam	and manner stated.	Ination and/	29c. Lican D 1	opinion, death occi ise number 4626	urred at the time,	date and place, and place, and place, and place signate January	and due to the cause(s) d (Month, Day, Year) 7 8, 1998



DHMH 16 Rev 6/95

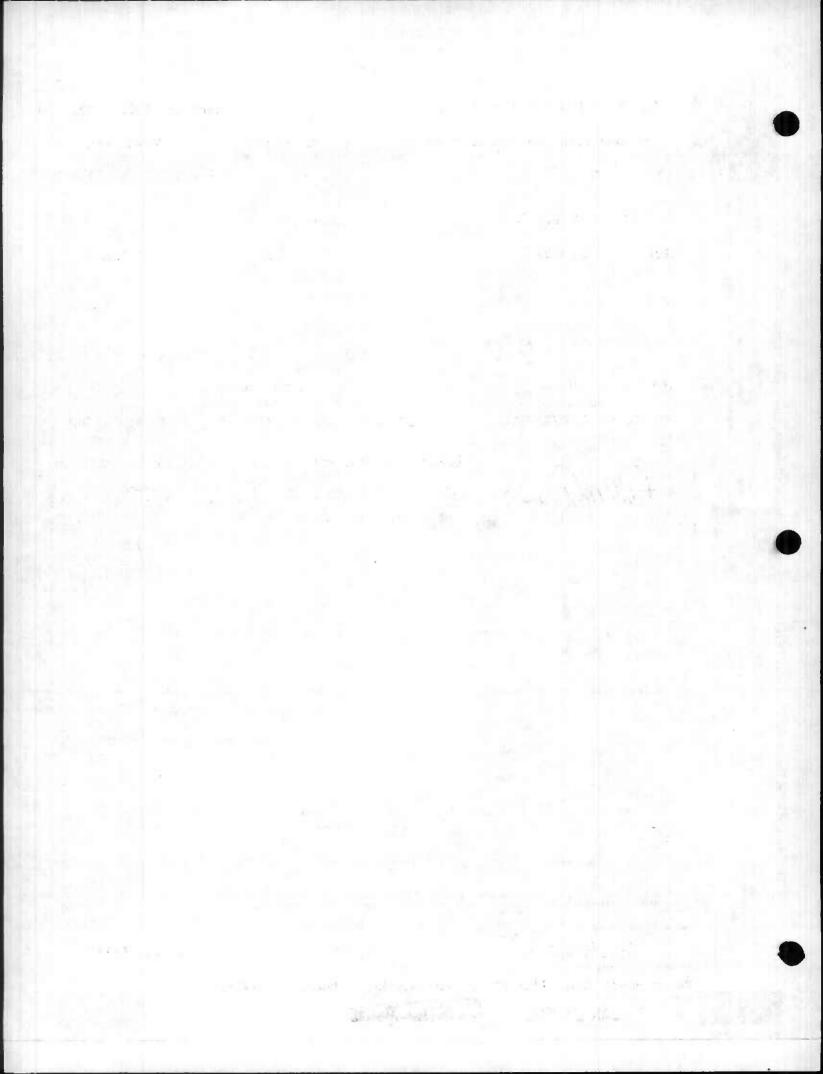
Registrar

JAN 20

JENNINGS

Virginia

Sarah



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 8 0 25 1 0

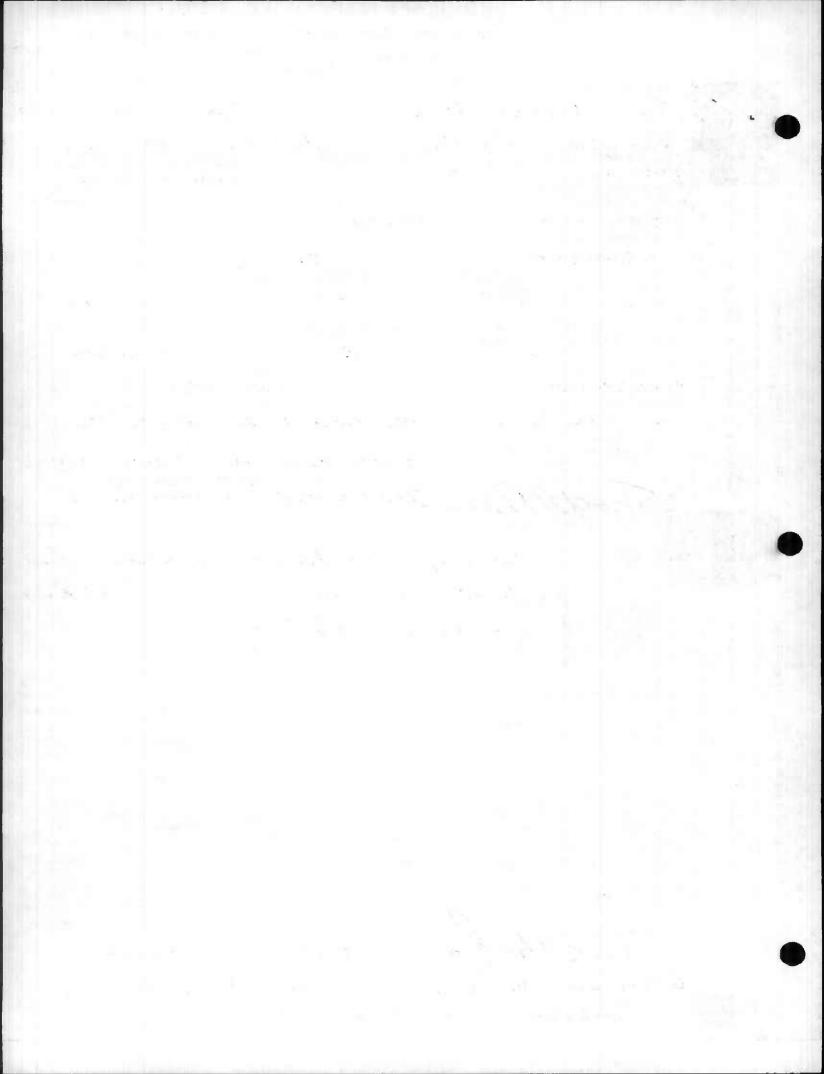
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Dhualain	_	1. Decedent's Neme (First, Middle,	Last)							2. Dete of D	Peeth Dev	Year	3. Tima of Dea
Physicia /Medica	_	Bertie Jo	neo							Janua		1998	215f
Examine	_	4a. Facility Name (If not Institution,	give street and n	umber)				4b. City, To	wn, or Lo	cation of Dea		ty of Deeth	
		5967 Grove Hill	Road					Frede	rick		Fred	erick	
uneral			S. Sex	7. Age (In y	rs. lest birtl		nder 1 Yea	r If Undar	24 Hrs.	8. Dete of B (Month, D			pleca (Steta or For
irector		219-34-5240	1□ M 2⊠ F		59 Y	rs. Mont	ths Days	Hours	Min.	Oct.	26, 1938	Mary	niny) (land
		Usual Residenca of Decedent											
H H		10e. State 10b. County		10c.	City, Town	or Location						1	10d. Inside City Li
1	용	Maryland Frederi	lck	Fre	ederi	ck							1 ☐ Yes 2/8
or 28	Directo	10e. Street end Number				10f.	. Zip Code				10g. Citizen o	Whet Cour	ntry?
23a	<u>a</u>	5967 Grove Hill	Road			2	1703				USA		
E E	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in	U,S.	13. Was De	ecedent of	Hispenic Ori ban, Mexical	gin? (Spe	ecify Yes or N		ce - Americ	
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E S	þ	3 ☐ Widowed 4 ☐ Divorcad	Yeer or			I L Te	וא נאַכ	э эрөспу.			Spec	<i>⊪y:</i> Whi	ite
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ven	Be	17. Fether's Neme (First, Middle, La	est)					18. Mothe	er's Name	(First, Middle	a, Maidan Suma	ıma)	
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EE		19a. Informent's Neme/Reletionshi	p (Type, Print)		19b.	Mailing Add	ress (Stree	et end Numb	er or Rura	al Route Num	ber, City or Tow	n, Stete, Zip	Code)
em 27 li other tra		Martin Jones, hu	isband		596	67 Gro	ve Hi	11 Ro	ad,	Freder	ick, MD	2170	03
		20e. Method of Disposition			. Plece of	Disposition (Neme of			Dete	20c. Location	- City or To	own, Stete
mportant: If ite any injury or o		1 ☐ Buriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe				ven Me				/16/98		d = 1	1 ·
2 %		21. Signature of Eunaral Service Li		I	estila						Funeral	ICK,	Maryland
any ir		1) -								ederick		21702
	-	23a. Part1. Enter the disease, or co shock, or heart feilure. List or	elers	2			_					FID	Approximata
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miner	aminer	disaesa or condition rasulting in deeth)	e. Les	Due to	(or es e co	onsequence	of):						
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State of Maryland / Department of Health and Mental Hygiene 8 0 2 5 1 2

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State of Maryland / Department of Health and Mental Hygiene

					Cert	tificat	te of i	Death		Re	g. No.	Ud	1010
Physici	an	1. Decedent'a Name (First, Middle, La	ist)							Dete of Death	Dey	Year	3. Time of Dear
/Medic		Cathe	rine Eliz	abeth	Koser					nuary	11, 1		8:50 A.
Examin	er	4a. Fecility Name (If not institution, give						b. City, Town			4c. County	of Deeth	
		Citizens Nurs					_		lerick			ederi	ck
Funeral Director			IDM 201F	Nge (In yrs. 88	last birthday) Yrs.	Months	Deys	If Under 24 Hours I	Min. (Date of Birth Month, Day, 11y 5,			ece <i>(State or For</i> try) nsylvani
ehow	or	10a. Stete Maryland Freder	ick	10c. Cit	y, Town or Loc	ation	Fred	erick				10	Od. Inside City Lin
or 28a-f	Directo	10e. Street end Number	Reichs Fo	rd Ro	ad	10f. Zip	Code	21	704	10	g. Citizen of	Whet Coun U.S	try?
/z nours ener cearn with the Marylend naturel, or items 23a or 28a-f show deal Examiner mant be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Deceder Armed Forces	t Ever in U	S. 13. W			spanic Orlgin n, Mexican, P		Yes or No- n, etc.)		ce - America	an Indian, etc.
urel', or		3 ☐Widowed 4 ☐ Divorced	1 ☐ Yes 27 If Yes, Give Year or Dates	:	11	☐ Yes	2 No	Specify:			Specif	y:	White
- 61	Completed	15. Decedent's E (Specify only highest gr			16a. Decede (Give k	ind of wo	el Occupi	ation luring most of)	working	1	6b. Kind ot B	usiness/Ind	ustry
iene. The Me	ошо	Elementary/Secondary (0-12) 1st grade	College (1-4o	5+)	Homema		30 7011700	,			Own 1	Home	
other ont,	Be C	17. Father's Neme (First, Middle, Last)					18. Mother's	Name (Fir	st, Middle, M	aiden Sumar	ne)	
Aenta rked tic ev	To B	David	Martin					S	arah	Lining	ger		
ith and Mental I		19a. Informent's Name/Relationship (Gloria M. Sier/Dat	Type, Print) ughter		19b. Mailing 8826 R	Address	s (Street a	nd Number o	r Rural Ro	ute Number, ederic	City or Town	State, Zip 21704	Code)
permit. Feges i and 2 should be listed with Deportment of Health and Mental Hygiene. Important: If Nem 27 is marked other than any Injury or other traumatic event, the Mones.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special		C	laca of Disposi emetery, creme Olivet	atory or o	other plac	_{e)} y Ja			oc. Location		wn. Stete c, Maryl
Depertment important: If any Injury or once.		21. Stringure of Funeral Service Lices 23e. Pert1. Enter the disease, or com shock, or heart tailure. List only	hacken	LMOO	Ko	onor	C D	s of Facility asford	Fune	ral Ho	ome		
	/Medical Examiner	Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest	b	Due to (o	r as a consequer as e consequer es a consequer	enca of):		ance	'n				Pav
attendir for use	clan											Ì	
ed by the attend	Physician/	Part II. Other significant conditions of	ontributing to death	but not resi	alting in the unc	derlying o	ause give	en in Pert I.		23b. Did tot 1 □ Ye			the cause of dec ably 4 Unkn
hes been signed by	Completed by									24a. Was en perform		eve	re autopsy tinding ileble prior to appletion of cause leeth?
ate h	Som									1 ☐ Ye	2 No	1□	Yes 2□ No
certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place of	Death (Ch	eck only one)		
	2	1 Yes 2 No			ER/Outpatient		-	4 LS-MOTSIF			ice 6 Oth)
or death. ector: After by the funer	atlon	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		ay Year)	28b. Time of Injury	M	28c. Injury Work 1 🗆 `	at :? ∕es 2 □ No	28d. i	Describe how	v Injury occur	red	
를 다 다	Certification:	3 Suicide 6 Could not b 4 Homicide determined	288. Place of II	njury - At ho otc. (Specify	ome, farm, stree	et, factor	y, offica		28f. L	ocation (Stre City or Town,	eet and Numl State)	er or Rura	Route Number,
within 24 hours To the Funeral completely filled	edicai	29a. Certifier (Check only one)	ysician: To the bes	of examinat	wledge, death o ion and/or Inve	occurred estigation	at the tim	e, date and p Inion, death o	lace, and d	lue to the car the time, da	use(s) and mi te and placa,	anner as sta and due to	ated. the cause(s)
withir comp	Me	29b. Signeture end title of certifier				290	c. License	number	_	29	d. Date signe	d (Month, L	Day, Year)
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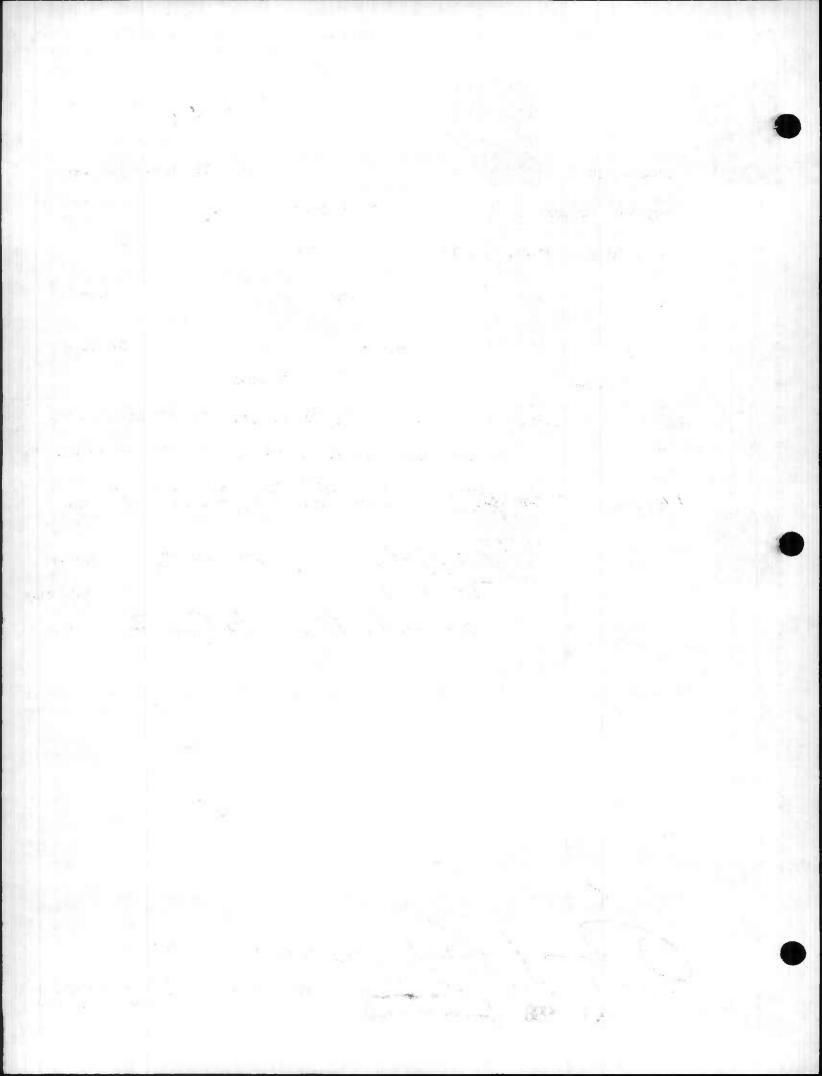
DHMH 16 Ray 6/95

icia		1. Decedent's Name (First, Middle, Las	1)		Oerti	ificate of	Death	2. Date of		UZ	3. Tima of Death		
dica		IGNATIUS EMORY LEASE						Jan.	8, Dey 19	98	1:43 PM		
nine	_	4a. Facility Name (If not institution, give Northampton Manor					4b. City, Town Freder	or Location of De		4c. County of Death Frederick			
al		5. Sociel Security Number 6. Se	7. A	ga (In yrs. las		If Under 1 Year	If Undar 24			9 Rirthn	lace (State or Foreign		
by Funeral Director	-	219-36-2696 1 Usual Rasidence of Decedent	34M 2□ F	93	Yrs.	Months Deys	Hours I	July	Birth <i>Oay, Year)</i> 7, 1904	Mary	Iand		
	-	10e. Stete 10b. County		10c. City,	Town or Loca	tion				10	Od. Inside City Limits		
	cto	Maryland Freder	ck	Fre	derick						1 ☐ Yas 2 🖺 No		
	Dia	10e. Street end Number 6109 Quinn Orchan	d Road			10f. Zlp Code	1701			Auctioneering			
	nera	11. Merital Status	12. Was Deceden	t Evar in U,S.	13. Wa			? (Specify Yes or uerto Rican, etc.)	No- 14. Ra	ca - Amaric			
	by Fu	1 Never Married 2 Marriad 3X Widowed 4 Divorced	1 Yes 24	No		Yas 2 No	Specify:	derio riloari, etc.)		he:			
		15. Decedent's Ed	Year or Dates		16a. Deceder	nt's Usual Occup	petion		16b. Kind of E				
	Completed	(Specify only highest green	College (1-4o	5+)		nt's Usual Occup nd of work dona NOT use retired		working		Bleck, White, etc. Specify: White 16b. Kind of Business/Industry Auctioneering faiden Sumeme) City or Town, Stete, Zip Code) n, Maryland 21769 20c. Location - City or Town, State			
		17. Fethar's Name (First, Middle, Last)			Au	ctionee		Name (First, Midd			ring		
9	To Be	George E. Lease					Naom	i Beall	Auctioneering (First, Middle, Maiden Sumeme) eall				
1		19a. Informent's Neme/Relationship (7											
		Margaret N. Guyto 20e. Method of Disposition	n/Daught	20b. Plac	ca of Disposit	ion (Neme of							
eny injury or other		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		9	-	tory or other place vet Ceme		1/12/9	8 Freder	ick,	Maryland		
		21. Signature of Francis Service Lifen	ss of Fecility	EY & SON FUNERAL HOMES, P.A.									
2000	1	Toket C	tailer	191				& SON F T ST., F diac or respiretory					
1		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ne cause on sach	ine.	Do not anter	the mode of dyir	ng, such es ca	diac or respiretory	errest,	1	Approximate interval Between Onset and Deeth		
	- 1	Immediate Ceuse (Final disease or condition		Neun	nna				luh				
		resulting in deeth)								İ			
	Examiner	Sequentially list conditions	b. ———	Due to (or e	s a conseque	nce of):							
1	EX	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury	6										
	O	Celuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of):											
1	M/UE		d										
	Physician/M	Pert II. Other significent conditions co	ntributing to death	but not resulti	ng in the und	arlying cause giv	en in Part I.	23b. D	23b. Did tobacco use contribute to the cau				
1		Bone Mar	row .	foilu	re			11	Yes 20 No	3 Prob	eably 4 Unknown		
	2			1	0				as en eutopsy	24b. We	re eutopsy findings bilabla prior to		
3	5	C	4					pe	rformed?	COF	npletion of ceuse deeth?		
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State of Maryland / Department of Health and Mental Hygiene

Physici		1. Decedent's Neme (First, Middle, L	ast)					2. Dete of Dee		3. Time of De	
/Medic		Ki Mook	LEE					January	7° 1998°	7:00	
Examin		4e. Fecility Neme (If not institution, give street end number) 4b. City, 1						Location of Deeth 4c. County of Montgol			
Funeral Director			Sex 7. A	ge (In yrs. le 92	est birthdey) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs Hours Min.		Year 1905 Sc	Birthplece (State or F Country) Outh Korea	
of show	tor	10a. State 10b. County	omery	10c. City	, Town or Loc	Gaithe:	rsburg			10d. Inside City I	
23s or 28a-f show	al Director	10e. Street end Number 9032 Mahogany	Drive, Apt	. 107	7	10f. Zip Code	20878		og. Citizen of When		
al', or items Examiner m	by Funeral	11. Marital Status 1 Never Merrled 2 Married 3 Novidowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 28 If Yes, Give Yeer or Dates:	?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indien, Bleck, White, etc. Specify: Asian			
than "natural", the Madical Exp	Completed	15. Decedent's Elementary/Secondery (0-12)	cedent's Education highest grede completed) 0-12) College (1-4or 5+		(Give I	ent's Usuel Occupetion ind of work done during most of w O NOT use retired) naker		rking	16b. Kind of Busine	oss/industry Own Home	
ced other	To Be Co	17. Father's Neme (First, Middle, Las Unknown	t)					me (First, Middle, nown	Meiden Surneme)		
27 is mar) r traumati	F	19e. Informent's Neme/Relationship Sook Ja Won / Dat			19b. Meiling	Address (Street	end Number or Ri Drive,	ural Route Numbe Apt. 107	r, City or Town, Stei Gaither	te, Zip Code) sburg, Md.	
mportant: If Item any injury or othe		20e. Method of Disposition 1		20b. Place Rest	ace of Dispos metery, crem haven	ition (Neme of etory or other ple Memorial	[©] Gardens	Jan. 10	20c. Location - City , 1998 F	or Town, State rederick,	
sician and and and se es the private transit	Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underfying Ceuse (Disease or Injury that Initiated events resulting in death) Lest	e	Den Due to (or	es a consequence of the conseque	lead ince of):	ny	Arra	diale	luin eyea	
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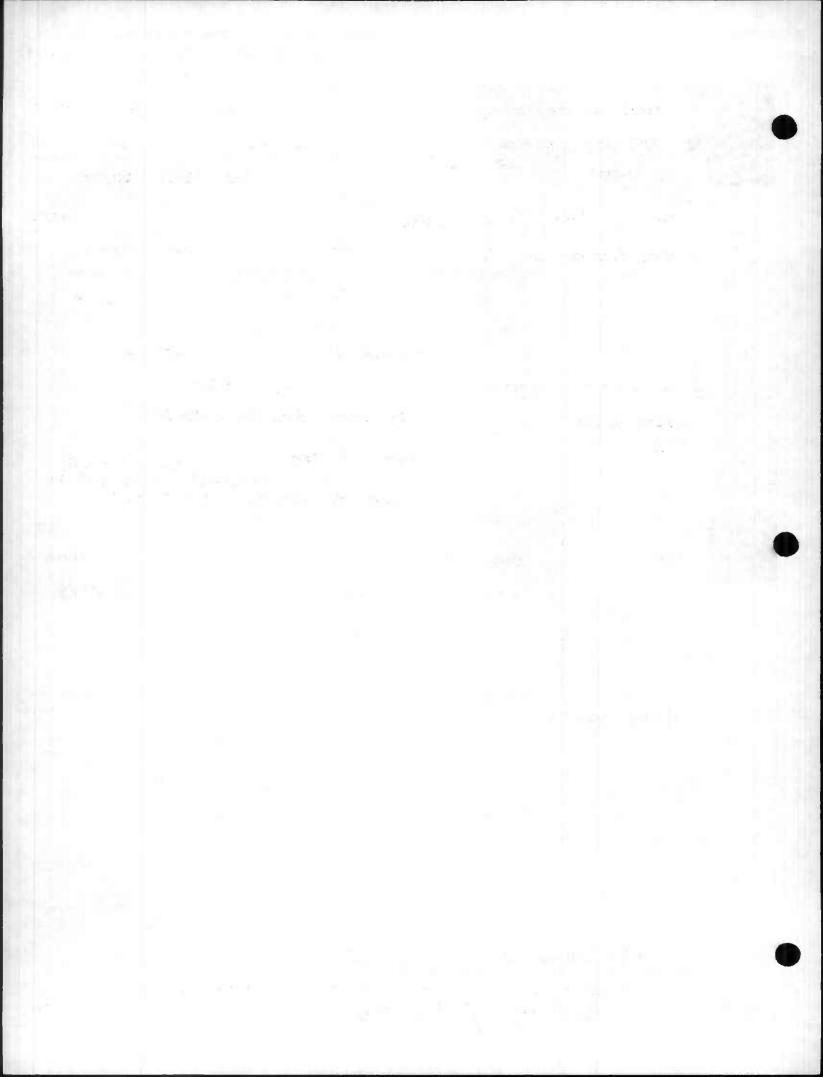
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State of Maryland / Department of Health and Mental Hygiene 0 25 | 6

					U	FI UIIICO	ale UI	Death			Reg. No.				
Discontin		Decedent's Neme (First, Middle, Las	st)		100					2. Dete of Dec		Year	3. Time of D		
Physic /Medi		Pearl Alberta	Medley							Jan.		1998	4:00		
Exami		4e. Fecility Neme (If not institution, give	e street end number	r)				4b. City, To	wn, or Lo	cation of Death	4c. Cou	nty of Deeth			
		9705 Piscatawa	y Road						nton			. Geo.			
Funeral Director		5. Social Security Number 6. S 220–34–7828	ex M XX F 7. A	Age (In yrs. 82	lest birthda Yrs.	Month	der 1 Yeer S Deys		Min.	8. Dete of Bird (Month, De Jan 3,		9. Birthp Coun Mary]	lece (State or I		
n 72 hours efter death with the Menyland "neturel", or Items 23e or 28e-f show spiral Evernible must be notified at		Usual Residence of Decedent								Jan 1	1710				
		MD P.G.		10c. Cit	ty, Town or	Location						1	0d. Inside City		
	Director			C	Lintor								1 ☐ Yes X		
		10e. Street end Number 9705 Piscatway R	oad 10f. Zip Code 20735												
	by Funeral	11. Maritel Stetus 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 22 If Yes, Give	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Blec Yes 202 No				Bleck, While,	/hile, etc. Black						
afri	ted	15. Decedent's Ed	lucetion		16e. Dec	edeni's Us	suel Occu	pation			16b. Kind o	Business/Inc	dustry		
ena. than	Completed	(Specify only highest gre- Elementery/Secondery (0-12) 12	College (1-4or	r 5+)		DO NOT Sekee		during most	of workir	ng	Domes	stic			
T to		17. Fether's Neme (First, Middle, Last)			House	JC 100	PCL	18. Mothe	r's Name	(First Middle		Kind of Business/Industry Dimestic En Surneme) For Town, State, Zip Code) 20735 Location - City or Town, State inton, Maryland Ome, Inc 6633 Old			
D 0	Be c	Frederick Oscar								nes Lec					
and and	То	19a. Informent's Name/Reletionship (1) Arlene Duckett			19b. Me	iling Addre	ss (Stree					vn, Stete, Zip	Code)		
m 2				20h E					, 01						
permit. Pegas 1 er Dapartmant of Hea Important: If itam; any injury or othar once.		20a. Method of Disposition 1 1 Buriel 2 Cremation 3 4 Donetion 5 Other (Specify		8	Plece of Disponentery, cr SULTE					Dete					
		21. Signeture of Funeral Service Licen	see //	7							L Home	,Inc 6			
		Alexandria Ferry Rd, Clinton, Md 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, intervel Biometries Biometries and the death of the complete such as the comple										Approximete			
nysician Medical												1	Onsel end De		
Examiner			a LEVILLE	10	37RU7	was							& wee		
		resulting in deeth)	e	Due to (ores a cons	equence o	if):						& Wee		
sit	iner	resulting in deeth)	b. CAN	Due to (c	ores a cons	equence of Calo	nf):						8 Wee.		
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rysician and ha bunal-transit		Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	b. <i>CAN</i>	Due to (d		equence o	f):						7 Wee		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Dete of Deeth Month MARGARET ELAINE MITCHELL JANUARY 4c. County of Deeth 4e. Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 3400 HOLLOWAY SOUTH hirthday) If Undar 1 Yaar UPPER MARLBORD PRINCE GEORGES DRIVE Hundar 24 Hrs. 8. Data of Birth (Month, Day Yaar) March 29, 1937 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) New York 6 Sax Months Days 1□ M 25F 055-32-5186 60 Yrs. Usuel Residence of Deceden 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XI No New Jersey Cumberland Vineland 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 1348 Venezia Avenue 08360 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Giva Yeer or Dates: 13. Was Decedant of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - Amarican Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XX Specify: White Specify 3 X Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Clarence Crowter Alice Fudger 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Szwarc (Daughter) 3400 Holloway Drive South Upper Marlboro, MD 20772 20e. Method of Disposition 20b. Plece of Disposition (Nema of cemetary, cramatory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removel from Stete Jan. 21, Bridgeton New Jersey Laurel Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1998 Lee Funeral Home, Inc. 21. Signature of Funeral Se 22. Name and Address of Fecility 6633 Old Alexandria Ferry Rd Clinton MD 20735 23a. Perf. Enter the disease, or complications that o used the death. Do not antar the mode of dying, such es cardiac or raspiratory arrest, shock, or heart feilure. List only one cause and all hine. Approximata Intervel Between Onset end Deeth HYPERTENSIVE Immediate Cause (Final ARTERIOSCIEPATIC CARPIOVASCULAR diseese or condition resulting in death) Due to (or as a consequence ot): Dua to (or es e consequence ot) Due to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings eveileble prior to completion of ceuse of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

sician and burial-transit

attending physician for use es the burial

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signed by t

should I

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funeral

illed in by

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific

Box 68760

P.O.

Records.

Division of Vital

Physician

/Medicai

Examiner

Director

Funeral

by

Completed

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Examiner

Physician/Medical

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Certification:

Medical

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be notified at

permit. Peges 1 end 2 should be filed within 72 hours efter to Department of Health end Mental Hygiene. Inportant: If item 27 is merked other than "natural", or iter any Injury or other traumatic event

Baltimore, Maryland 21215-0020

with the Maryland

death

Sequentially list conditions, if eny, laading to immediata ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In deeth) Lest

4 Homicide

31. Dete tiled (Month, Day, Year)

29a. Certifier

Part II. Other eignificent conditions contributing to death but not rasulting in the underlying ceuse given in Part I.

25. Wes case reterred to medical examiner? 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner ot Deeth 28b. Time of

28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

JAN 2

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and menner es steted.

2 Medical Examinar: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end dua to the ceuse(s) and menner stated. icetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, end dua to tha causa(s) 29d. Date signed (Month, Dav. Year)

28d. Describe how injury occurred

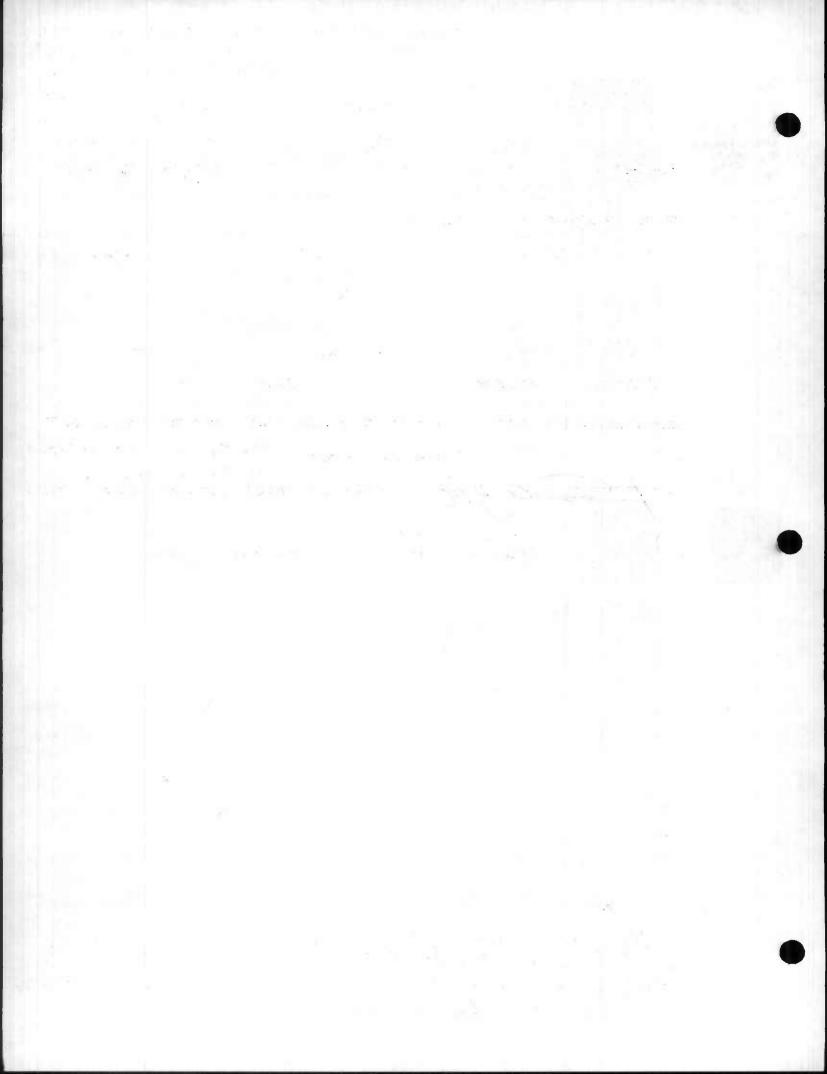
30. Name and address of person who com d cause of deary (ten 23e) (Type, Print)

1998

GOLVE

300 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 MO 32. Registrars Signature 8

State Registrar

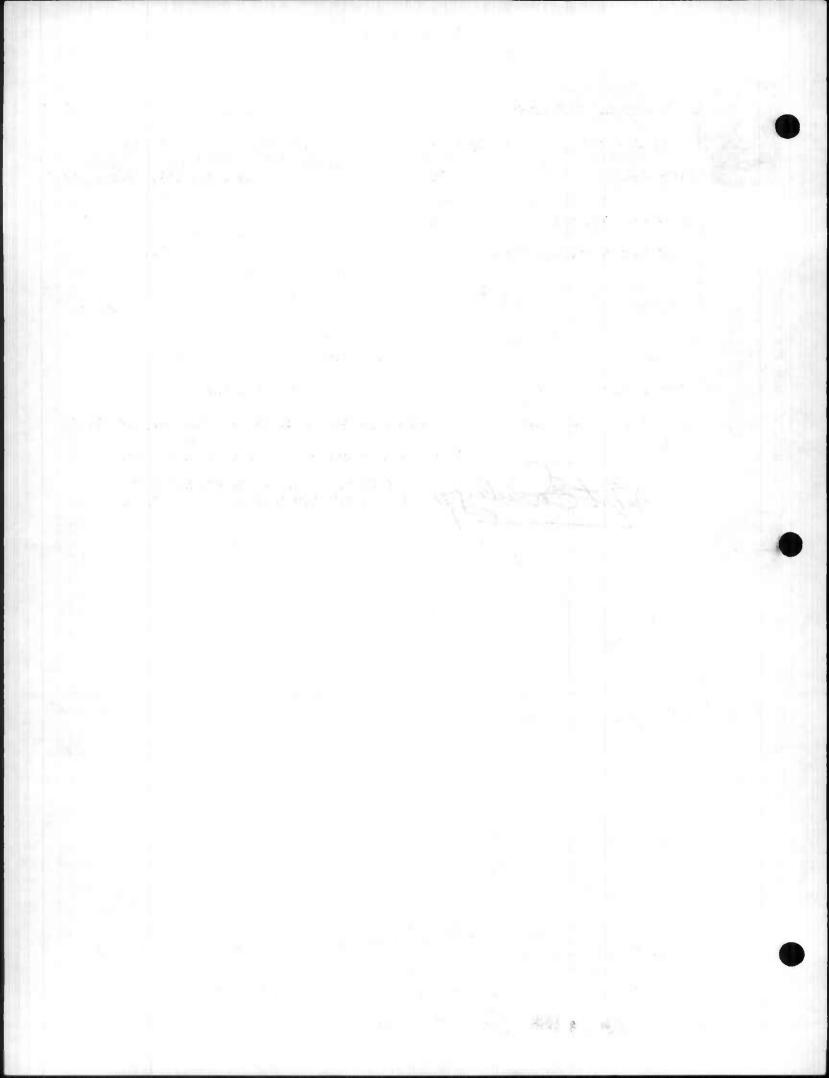


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State of Maryland / Department of Health and Mental Hygiene | 8 | 0 2 5 | 8

					Cer	tificate o	f Death		Reg. No.			
Physician /Medical		Decedant's Name (First, Middla, Last)						2. Data of D Month	eath Dey	Yeer	3. Time of Deat	
		HOWARD C. MCALI						Jan.			2:50	PM
Examin	er	4a. Facility Neme (If not institution, gi	ve street end number)				4b. City, Town	, or Location of Dea	th 4c. Count	y of Death		
		Northampton Man	nor Nursing	g Home				erick	Fre	ederick		
Funeral Director			Sax 1 M 2 □ F	a (In yrs. last	Yrs.	If Undar 1 Ya Months Day		Min. (Month, D	irth ay, Year) 1, 1911	9. Birthplac Country Penns		
within 72 hours effer death with the Maryland liene. than "netural", or items 23a or 28s-f show the Medical Examiner must be notified at		10a. State 10b. County		10c. City, T	own or Loc	ation				100	I. Insida Cit	ly Lim
	ector	Maryland Frederi	.ck	Frede	erick	101 71 0 4					1X Yas	2
	Funeral Director	200 East Sixteenth Street				10f. Zip Code 2170	1		10g. Citizen of What Country? U.S.A.			
	by	11. Marital Status 1 □ Navar Marriad 2 □ Marriad 3 ☑ Widowad 4 □ Divorced	12. Was Dacedant Armed Forcas? 1 ☐ Yas 2 XI If Yas, Giva Year or Datas:			/as Decedant of Yes, specify C		? (Spacify Yas or N Puarto Rican, etc.)	o- 14. Ra Bia Specia	ce - Amarican ick, Whita, etc fy: Whi	2.	
natur lical	ted	15. Dacedant's E (Spacify only highast gr	ducation	location 16a. Decedent's Usual Occupation 16b. Kind		16b. Kind of E	Businass/Industry					
r than	Completed	Elamantary/Secondary (0-12)	Collega (1-4or 5	(Giva kind of work dona during most of working ifa. DO NOT usa ratired) Technician Univ. of				of MD	MD			
	Bec	17. Fathar's Name (First, Middla, Las					Nama (First, Middle					
	To	Thomas J. McAllis		Bude	d Ferrier							
DE E		19a. Informant's Name/Relationship	(Type, Print)	1.34	19b. Mailing	g Addrass (Stre	et end Number o	or Rural Routa Num	ber, City or Town	, Steta, Zip C	ode)	
Health e em 27 is other tra		Mr. Howard McAll:	ister		3520	Bigwood	s Road,	Ijamsvil	le, Mary	land 2	1754	
Permit. Pages Department of Department of Important: If it and injury or or once.		20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Othar (Speci		cam	atary, crem	ition (Nema of atory or other p 1 Cemet	olaca)	Data 1/19/98	20c. Location - City or Town, Stata			
		21. Signatura of Fungral/Sarvige Lice	Haile	if					IERAL HOMES, P.A. DERICK, MD 21701 Perrast, Approximeta Intarval Batween			
	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated avants resulting in death) Last	C	Dua to (or as	a consequ	uance of):			H		nen	-
death cer e attandin ed for use	Physician/M	Part II. Other signiffcant conditions of			62		givan in Part I.		I tobacco use co			/
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certificate	e C	25. Was casa raferred to medical							Yas 2 12 No	101	es 2	No
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After th	atlon: To	27. Manner of Death 1 Statural 5 Panding 2 Accident invastigation	28a. Date of Inju (Month, Day	ry 28	Outpatient b. Tima of Injury	28c. In	4 Universi		how injury occu			
	Certification:	3 Suicida 6 Could not to datarmined		ury - At homa :. (Specify)	, farm, stra	at, factory, offic	ce .	28f. Location City or To	(Street and Num. own, Stata)	ber or Rural F	Poute Numi	ber,
	7	29a. Certifiar 1 Certifying Pl	nysician: To the bast of miner: On the basis of end manner sta	examinetion	dga, death and/or inve	occurrad at tha estigation, in m	time, dete end p y opinion, deeth	lace, and dua to the occurred et tha tima	causa(s) and m , data and place,	enner es stet and due to th	ad. ne cause(s)	
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vithin 24 hours To the Funeral Completely fille	Medic	one)	completed cause of d	eath (Item 23	e) (Type, P	20	onsa number	mi	29d. Dete signe	ed (Month, Da	y, Year)	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

					Cei	rtificate of	Death			Reg. No.	U	2013
Dhuni	1	1. Decedant's Name (First, Middla, La	ist)						2. Date of De Month		Veer	3. Tima of Death
Physic /Med		LaClair	F. Ma	ttes					January	10, 19	998ar	8:30PM
Exam		4a. Facility Nema (If not institution, give	e street end numb	er)			4b. City, To	wn, or Lo	ocation of Death	4c. County	y of Death	
		Frederick Healt	h Care C	enter			Fred	eric	k	Fre	ederi	ck
Funera		Social Sacurity Number 6. 8		Age (In yrs. lest i	birthday)	If Under 1 Yaar			8. Deta of Bin (Month, Da	th	9. Birthr	placa (Steta or Foreign ntry)
Directo		332-16-9545	1 X M 2□ F	79	Yrs.	Months Days	Hours	Min.	Feb. 3,	1918		inois
ש		Usual Rasidance of Decadent										2110 20
ylan		10a. Stata 10b. County		10c. City, To							1	Od. Insida City Limits
Ma	to	Maryland Frederi	.ck	Fred	leric	k						1XXYas 2 ☐ No
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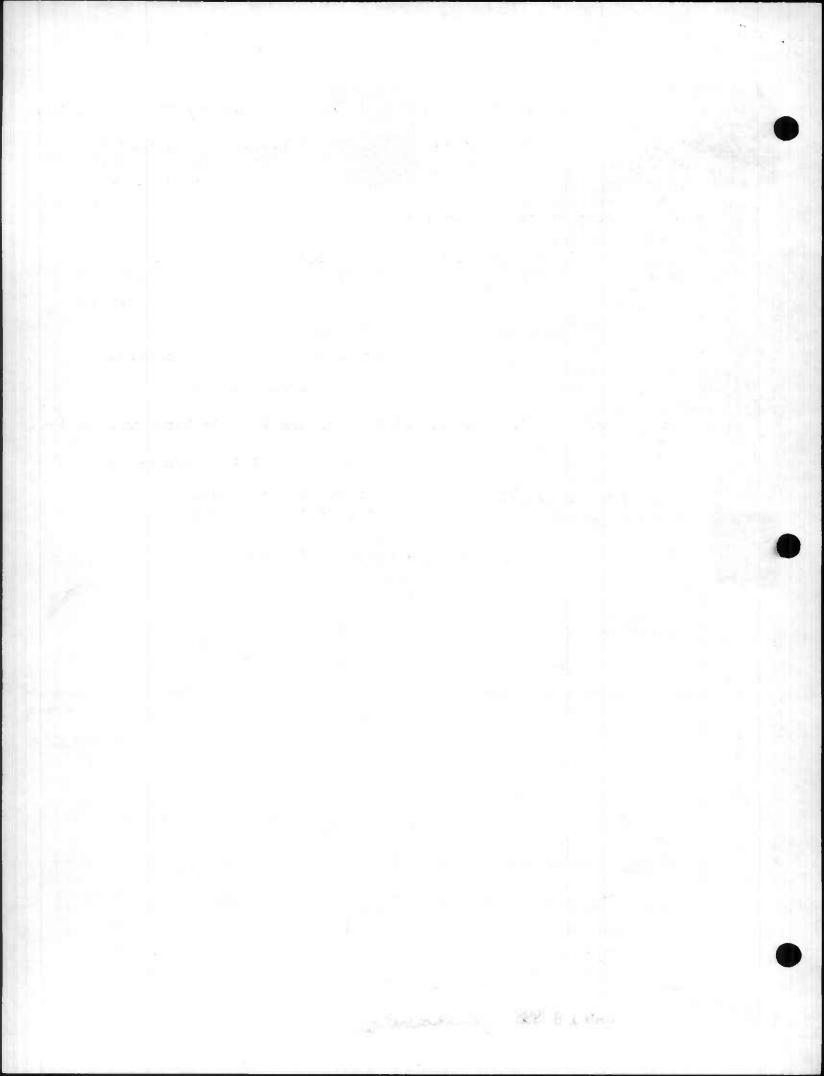
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3 Time of Death Month **Physician** Dorothy Z. Mills January 10, 1998 12:40 PM /Medical 4b. City, Town, or Location of Daath 4a. Facility Nama (If not institution, give streat and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Yaar If Undar 24 Hrs. Months Days Hours Min. Social Security Number 163 14 6031 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2 X F Months 76 Yrs. Director June 30 1921 New York Usual Residence of Decedant the Marylend 10a. Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumstic event, the Medical Examiner must be nothed at 10d. Insida City Limits Director MD Montgomery Dickerson 1 ☐ Yas 2 ☑ No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 22333 Nicholson Farm Road USA 20842 Funeral deeth 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 之☐ No If Yes, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, pemit. Peges 1 and 2 should be filled within 72 hours effer to Department of Health end Mentel thygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, its Medical Examples once. Black, Whita, etc. 1 ☐ Nevar Married 25 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White þ 3 Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Homemaker 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Joseph Reid Edna Staples 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Joseph Mason Mills Husband 22333 Nicholson Farm Rd Dickerson MD 20842 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) St. Mary's 1/15 Barnesville, MD 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Hilton Funeral Home Will 0 23a. Part 1. Entar the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) NON-Small Cell Lung Cancer Examine Dua to (or as a consaquance of) Examiner Gupty Serva

Dual (or as a consequence of): physician and s the buriel-transit The law requires that the death certificete be executed Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated events rasulting in daath) Last Box 68760. Physician/Medical Dua to (or as a consaquance of): for use as P.O. F signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ been si 24b. Wara autopsy findings available prior to complation of causa of daath? Completed 24a. Was an autopsy page 2 s certificate 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director. Be 25. Was casa raferred to medical axaminar? 26. Placa of Death (Check only ona) 1 Yas 2 No Hospital: 1 Suppatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) Certification: To 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicide 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 10 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signatura and titla of certifian 29c. License number 29d. Data signad (Month, Day, Yaar) Tolino MD MD 0516100 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Suite 204 Ave 21702 Taney Frederick MD 31. Data filad (Month, Day, Yaa 32. Ragistrar's Signatura State

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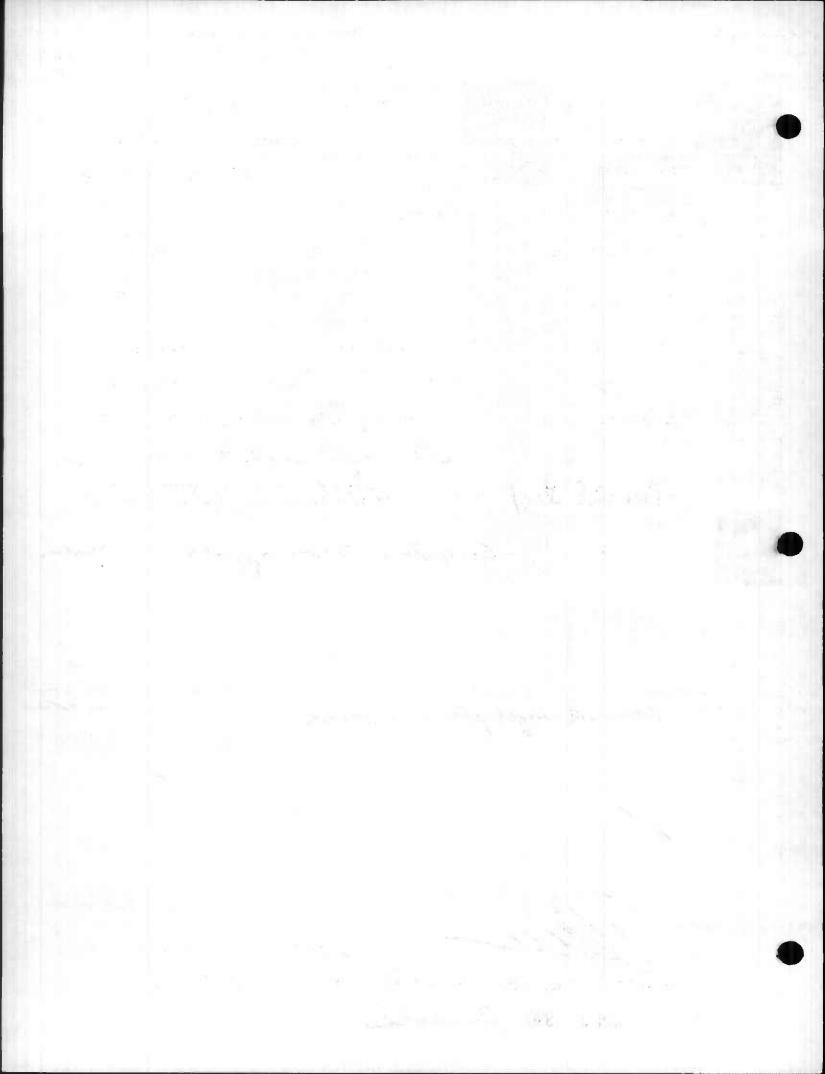
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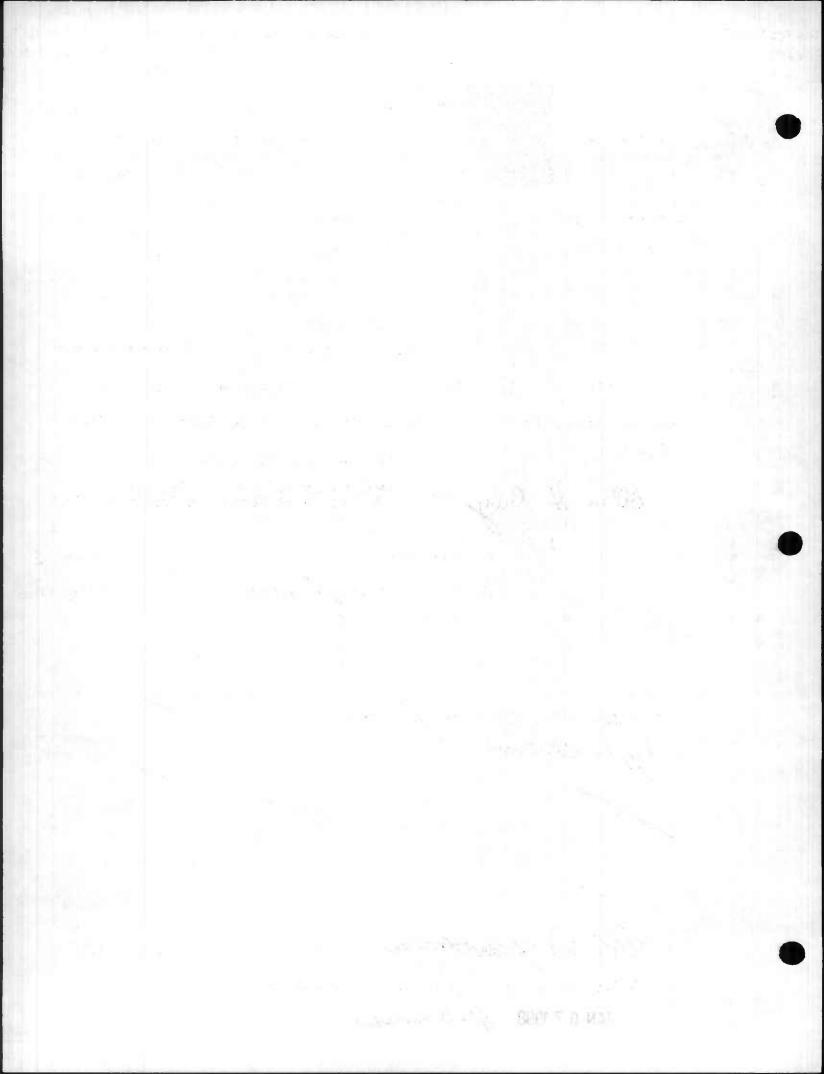
State of Maryland / Department of Health and Mental Hygiene

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(Check only one) 2U Medical Sammer: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and menner steted. 29b. Signature and Ma of certain 29d.								d (Month, Day,	Year)
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State of Maryland / Department of Health and Mental Hygiene Q

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d 21215-0020 filed within 72 hours after death with the Maryland thygiena. ther than *natural; or items 23s or 28s-f show ont, the Med cell Examinat must be notified at	by Funeral	11. Maritel Status 1 Navar Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar in L Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:			of Hispanic Origin? (\$ Cuban, Maxican, Puer No <i>Specify:</i>	Spacify Yas or No to Rican, etc.)		umerican indian, White, atc. White
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ld be ental ked o	To Be		William EHML	ING				E. SCHMEI	TZER
Maryland d2 should be file th end Mental Hy 7 is marked othe traumatic event	-	19a. Informent's Name/Ralationship (T			ing Addrass (St	reat and Number or R			
CENL		Janet L. Michael,	Friend	750 0	Carroll	Parkway, 1	LO-A, Fr	ederick, M	D 21701
0 80 1 2		20a. Mathod of Disposition 1	20b.	Place of Dispo cematary, cra	osition (Nama o	placa)	Data	20c. Location - City	or Town, Stete
Limor Peges Iment of land: If Its		4 Donation 5 Other (Specify,	Mo	unt 01	ivet Ce	metery, Ja	n. 8, 19	8 Frederi	ck, Maryland
Baltimore, permit. Peges 1 at Department of Has Important: if Itam; any injury or othe		21. Signature of Funeral Sarvice Licens	no		Keenev	ddrass of Facility & Basford t Church S	P.A. Fu	neral Home Frederick,	MD 21701
		23e. Pert1. Entar tha disaasa, or comp shock, or haart failura. List only of	lications that caused the dear	th. Do not an	ter tha moda of	dying, such es cardia	c or respiretory e	rrast,	Approximata intarval Batween
Physician /Medica Examine		Immadiata Causa (Final disaasa or condition rasulling in daeth)	Pre	umo	nia				Onset end Death
		rasuming in daem)	Due to (or as a conse	quanca of):	1			10 week
uted J ansit	Examiner		ally	heis	mers	desea	se		10 year
o, exec an an	EXa	Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Causa (Disaasa or injury that initiated events	Due to	or as e consec	quenca or):				
68760, ificete be executed g physician and as the buriel-transit	edical	Causa (Disaasa or injury that initiated events rasulting in daath) Last	cDua to (c	or as a consec	quanca of):				
T Die	100								
Box eath cert ettandin for use	lan/		d						
het the death certed by the ettandin	Physician/N	Part ii. Other elgnificant conditiona co		-	1	_	23b. Did	tobacco usa contrib	uta to the cause of death?
T & 2 5	by Ph	Chronie	renal	fa	elare		10	Yes 2 No 3	Probably 4 Unknown
aw request section is been 2 should	Completed b	hyperte	renal					an autopsy 24 ormed?	b. Wara autopsy findings evallable prior to completion of causa of daath?
	W O	/-					10	Yas 2 No	1 ☐ Yas 2 ☐ No
ysician: The ysician: The sectificata director, pag	Be (25. Was casa rafarred to medical examinar?			1	26. Piece of De	ath (Check only	ona)	
_ \$ 00	2	1 Yas 2 No		ER/Outpatier			1	danca 6 Other (S	Specify)
on on olding Phy. After the funaral	tion:	27. Manger of Death 1 Natural 5 Panding 2 Accident invastigation	28a. Data of injury (Month, Day Yaar)	28b. Tima o injury		injury at Work? 1 ∐ Yas 2 ∐ No	28d. Dascribe	how injury occurred	
UIVISION Hospital or Attanding I 24 hours after death. Funeral Director: After	Certification:	2 Accident Invastigation 3 Suicide 6 Could not be datermined	28a. Placa of injury - At h building, atc. (Specia	oma, farm, str fy)			28f. Location (City or To	Street and Number of wn, State)	r Rural Routa Number,
To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Cartifier 1 Cartifying Phy (Check only one) 2 Medical Exami	e, and dua to tha urred at tha tima,	cause(s) and manne data and placa, and	r as steted. dua to tha cause(s)				
To the Within 2 To the comple	Me	29b. Signature and title of certifier	11 1	/.	29c. Lic	ense number		29d. Date signed (M	onth, Day, Year)
		· Which	efronte	Lus	2 1	35183		January 6	6, 1998
		30. Name and address of person who co	of seted cause of death (Iter	n 23a) (Type,	Print)				
		Ali J. Afrookteh	, M.D. 300 We	st Nin	th Stre	et, Frede	rick, MD	21701	
Si	ate	31. Data filad (Month, Dey, Yaar)	32. Registrer's Signa		0				



BALTIMORE, MARYLAND 21215-0020

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 . STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAN	CENTIF	TOATE	I DEAL	п	REG. NO.		
	DAISY, - NicolA	i			2. DAT MON			3. TIME OF DEATH 2:35 AMM
	570 17 7001 500	In yrs. last birthday) 10/ YRS.	MONTHS DAY		MIN. 7. DAT	E OF BIRTH D	ec .	BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOY	VN OR LOCATION		1 10	9c, COUNTY	
TOR	Bradford Daks Nursing +	-Rehap Ce	nt.	Clint	on		P.G.	
Ĭ Į	10e. STATE 10b. COUNTY		Y, TOWN OR LO	CATION				10d. INSIDE CITY
L DIF	MD P.G.	C	Linton					1 YES 2 NO
ERA	9605 Michael Drive			20735			Unite	of what country? ed States
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EYER IF FORCES? 1 YES IF YES, GIVE WAR OR D.		If yes		HISPANIC ORIG Mexican, Puerto Specify:		or No 14.	RACE — American Indian, Black, White, etc. Specify: White
G	15. DECEDENT'S EDUCATION	16a. DECEDENT'S	USUAL OCCUP	ATION	16	Sb. KIND OF BUS	INESS/INDUST	TRY
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	IGNe kind of the Do NOT of the Homemal		most of working		Own Ho		
N	17. FATHER'S NAME (First, Middle, Lest)			16 MOTHE	ER'S NAME (First,	Adiolotto Adulatus	Commont	
BE C	Edgar Edwards			Ida	Mae Be	ard		
10	190. INFORMANT'S NAME (Type/Print) Tofil T. Kaminski	9605	Michael Michael	el Drive	e, Clin	nber, City or Town	20735	io)
	1A) Burdal 2 Cremation 3 Removal from State cam	PLACE AND DATE	other place)					or Town, State
	4 Donation 5 Dother (Specify) 21. SIGNATURE OF EUNERAL SERVICE LICENSES	kland B	aptist	Cemete:	ry	Ric	nardsv:	ille, Virginia
	· //chal To							ome,Inc 6633 n,Md 20735
	23. PART i. Enter the disesses, or complications that caused	the death. Do	not enter the	mode of dyln	g, such as ca	rdiec or reapi	ratory arrest	Approximate
	ahock, or heart failure. List only one cause on elimmediate cause (Final disease or condition bilateral resulting in death)	sch iine.						interval Between Onset and Death days.
2	DUE TO (OR AS A	consequence o		heart	disease	2.		years.
ATIO	Sequentielly list conditiona, if any, leading to immediate	CONSEQUENCE O					···	voere.
CERTIFICATION	CAUSE (Disease or injury that initieted events resulting in deeth) LAST	CONSEQUENCE O	F):					years.
H H	d peptic ulc	er disea	se.					years/
2	PART II. Other aignificant conditions contributing to deeth b	ut not reaulting	in the underl	ving cause giv	ven in Part I.	24a. WAS AN	VPPCTIA	24b. WERE AUTOPSY FINDINGS
EDICAL	severe cerebral arterioscle			, ,		PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	severe cerebral arterioscie	LUSIS.				1 TYES 2	NO	OF DEATH?
Σ								1 TES 2 NO
N								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		OTHER:	L PLACE OF DEA	ATH (Check only o	one)		
YS	1 YES 2 NO 1 Inputient 2 ER/Outp	atlent 3 🗆 DOA		fome 5 🗆 Resi	dence 6 🗆 Oth	er (Specify)		
H	27. MANNER OF DEATH 28e. DATE OF INJURY	26b. TIM	IE OF 28c.	INJURY AT WORK?	28d, DE	ESCRIBE HOW IN	JURY OCCUR	D
≥	1 Natural 5 Pending (Month, Day, Year)	1113	M 1	YES 2	NO			
red BY	(Month, Day Year)	— At home, farm,			28f. LO	CATION (Street a y or Town, State)	nd Number or F	lural Route Number,
- 1	1 Netural 5 Pending Investigation 3 Suicide a Could not be determined (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year)	— At home, farm, (street, factory, c	office	281. LO	y or Town, State)		lural Route Number,
- 1	1 Netural 5 Pending Investigation 3 Suicide a Could not be determined (Month, Dey, Year) (Month, Dey, Year) (Month, Dey, Year) 2as. PLACE OF INJURY building, etc. (Special Country of the country of	At home, farm, i	street, factory, c	office	28f. LO	y or Town, State)	ner ea stated.	
BE COMPLETED	1 Netural 5 Pending Investigation 3 Suicide a Could not be determined 28s. PLACE OF INJURY building, etc. (Spec Centifier (Check only 1 Centifying Physician: To the best of my knowledge)	At home, farm, i	street, factory, c	date end place, and death occurred	28f. LO City and due to the city dist the time, dat	y or Town, State)	ner ea stated. I due to the ce	use(e) and manner ee stated.
E COMPLETED	1 Netural 2 Pending Investigation 3 Suicide a Could not be determined 28s. PLACE OF INJURY building, etc. (Special Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge one) 2 MEDICAL EXAMINER: On the best of examination 29b. SIGNATURE AND TITLE OF CERTIFIER	At home, farm, i	etreet, factory, c	date end place, and death occurred place. LICEN	28f. LO C/h and due to the ca d at the time, dat SE NUMBER	y or Town, State) ause(e) end men te end place, end	ner ea stated. If due to the ce 29d. DATE SIG	use(e) and manner se stated. SNED (Month, Day, Year) 1. 15 1998
BE COMPLETED	1 Netural 2 Accident 3 Sulcide a Could not be determined 28s. PLACE OF INJURY building, etc. (Specific Check only one) 2 MEDICAL EXAMINER: On the best of examination 29b. SIGNATURE AND TITLE OF CERTIFIER	At home, farm, of the dege, death occurrence on end/or investigation. ATH (TEM 27/7/)/pa. ANCH AVE	etreet, factory, c	date end place, and the control of t	28f. LO C/h and due to the ca d at the time, dat SE NUMBER	y or Town, State) ause(e) end men te end place, end	ner ea stated. If due to the ce 29d. DATE SIG	use(e) and manner se stated. SNED (Month, Day, Year) 1. 15 1998

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THE ST. LEWIS CO., NAME AND ADDRESS OF THE PARTY OF THE P

STATE OF ACTION MADE TO ACT OF STATE AND ACCOUNT OF THE STATE OF THE S

State of Maryland / Department of Health and Mental Hygiene

					Cei	rtificate d	of Death	7	F	Reg. No.	-	
		1. Decedenl's Neme (First, Middle	le, Last)		91 TQ				2. Data of Dea		V	3. Tima ol Death
Phys /Me			SISTE	R ROBER	TA N	EARY			JANUARY	7 Day	Year 98	2:22 A.M.
Exan		4a. Facility Nama (If not institutio					4b. City, T	own, or L	ocation of Deeth	4c. County	of Death	
		VILLA ST. MI	CHAEL				EMMI	TSBU	RG	FREI	DERIC	K
Funer	1	5. Sociel Sacurity Number		7. Aga (In yrs. las	st birthday)	If Under 1 Ye		r 24 Hrs. Min.	8. Data of Birth	h V. Year)	9. Birthp	placa (Stata or Foraign
Directo	r	214-54-6258	1 ☐ M 2 □ X F	90	Yrs.		,,,		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	MARY	LÁND
pu a		Usuel Residence of Dacedent 10a. Stata 10b. County		10c City	Town or Lo	cation						I0d. Inside City Limits
anylen show	7										'	1 ☐ Yes 2 ☐ No
the N	Director	MD FRED 10e. Street end Number	ERICK	E	MMITS	10f. Zip Cod	la			10g. Citizan of	Affron Cours	^
with with	ō		01//									wyr
eeth 23	Funeral	333 S. SETON		dant Ever in U.S.	13.1		727	nigin? (Sr	necify Yas or No-	U. S.		can Indien,
ftar d	F	1 Never Merried 2 Man	Armed For	cas?		f Yes, specify (uban, Mexica	an, Puerto	pecify Yas or No- Pican, etc.)	Ble	ck, White,	
Urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Vas Give	3 [^]		1☐ Yes 2页	No Specify	<i>/</i> :		Specif	WHI	TF
re, Maryland 21215-0020 s 1 end 2 should be filed within 72 hours after deeth with the Maryland fendsh and Mental Hygiena. The properties of the first	3	15. Deceden	it's Education		18e. Deced	dent's Usuel Oc	cupation			16b. Kind of B		
within 7 ena. "n	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-	4or 5+)	life.	kind of work do DO NOT use re	na <i>during m</i> o tired)	ist of wor	king	RELIGIO	ous c	OMMUNITY
212 od withinglena.	5	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5+		TE	ACHER				DAUGHTI	ERS O	F CHARITY
be filed that Hygie d other	Be	17. Fathar's Nema (First, Middla,					18. Moth	ner's Nem	ne (First, Middle,	Meiden Sumen	ne)	
should be ind Mental	1º		THOMAS	F. NEA	RY				CA	ATHERIN	E McE	VOY
Maryland d 2 should be file the end Mental Hy 7 is marked other traumatic event		19e. Informent's Name/Reletions	ship (Type, Print)		19b. Mallir	ng Address (Str	eet end Numi	ber or Ru	ral Route Numbe	r, City or Town	State, Zip	Code)
s 1 end if Heaith item 27 other tr		SISTER CAMILL	A HARANT					., E	MMITSBUF			
0 0 0		20e. Method of Disposition 1 □ Burial 2 □ Crametion	3 □Removel from S	con		sition (Neme o netory or other		i	Data	20c. Location	- City or To	own, Stata
Peg ment ant:		4 Donation 5 Dothar (S		ST.	JOSE	PH'S_		1/9/	98	EMMIT:	SBURG	, MD. 2172
Baltimo		21. Signature of Fuheral Service	Licensee		22	. Neme end Ad	Idress of Feci	lity S	KILES FU	INFRAL I	HOME	
m ans		John M	Male	1	2	10 W. M	AIN ST		MMITSBUR			7
		23a. Part1. Enter the diseasa, or shock, or heert feilura. List	complications that ca	used the daeth.	Do not ent	er tha moda of	dying, such e	s cerdiac	or respiretory er	rest,		Approximate Interval Between
Physicia	_		0	1 -	T			-	1 8	0		Onset and Deeth
/Medica Examine		Immediate Cause (Finel diseese or condition	· Vu	Lowe	V	um	n	IT	th (lest	mil	Van
CXAIIIIIE	100	resulting in daeth)		Due A (or a	s a consec	juence of):	4	1	- 1	01	1 -	
b sit	Examiner		. 8	lud	6	estra	inte	ut	inal	Lee	Lin	A
X 68760, satisficate be assocuted ding physician end se es the bunal-trensit	хап	Sequentially list conditions,		Dua to (or a	as a conseq	uance of):					(
60, be ay		Sequantietly list conditions, if eny, leading to immadiate ceuse. Enter Undarlying Cause (Diseese or Injury that initieted events	C		54							3
68760, efficate be an physician as the buria	Medical	thet initieted events resulting in death) Last		Due lo (or a	s a conseq	uance of):					1	
X entif	Me		d			~ .			Y.		i	
death of dea	San										i	
_ 0 4 %	Physician	Pert II. Other significant condition	ons contributing to dea	ath but not rasuiti	ing in the u	nderlying cause	given In Peri	l.	23b. Did to	obacco use co	ntribute to	o the cause of death?
P. Cod by detac		atheres	clerat	te C	and	avoi	scul	4	101	res 2 No	3 Pro	bably 4 Unknown
Records, P.O he lew requires that the e hes been signed by the age 2 should be detach.	d by					di	-0.		24a. Wes	an autoney	24h W	ere eutopsy findings
Ted Legan	ete					CAL	elou	l		med?	ev co	relieble prior to empletion of cause
Receipe se lew	Completed										ol	deeth?
= = = =									1 U Y	es 2 No	10	☐ Yas 2☐ No
of Vital I Physician: The this certificate	Be	25. Wes casa referred to medica axaminer?	Hospitel:					ca of Dea	th (Check only o	na)		
Physic this cral dir	10	1 Yes 2 No	101		R/Oulpatien	3LI DOA		lursing He	ome 5 Resid			y)
	Certification:	27. Menner of Deeth 1 Netural 5 □ Pendir	.8	n, Day Year)	8b. Tima of Injury		njury at Work?	781-	28d. Dascribe h	low injury occur	rad	
Attending or death.	Cat	2 Accident Invasti	nol be	flat a fit			1 Yas 2	1140	ORE Leasting /	Manada and At	hav av 0	- L Douts March -
Division or Attending efter death. Director: Aftai	T.	4 Homicida datam	ined 208. Place	of Injury - At hom g, etc. (Specify)	e, lerm, str	eet, fectory, off	ice .		City or Tow	m, State)	oer or Hure	el Routa Number,
Hospital or 24 hours effe Funeral Dir stely filled in		29a. Certifier 1V Certifvin	Dhualalan Tarka					- 4 - 1				
Division To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: complately filled in by the	edical		g Phyaician: To tha t Examinar: On the base and marni	sis of exeminetion	n end/or inv	astigetion, in m	a tima, data a ny opinion, de	ath occur	red et the time, o	date end plece,	annar as s and dua to	tated. tha cause(s)
ro the within to the compla	Me	29b. Signature and title of our file	· /	310100.	11	. 29c. Lic	ense number	9 1	_	29d. Date signe	id (Month,	Dey, Year)
F \$ F 0		> / 0 /	~ /	ALIN	0011		118	70	(LANULADA	7 1	000
		30 Name and address of a	4	qui	W.	Driet)	010	10)	IANUAR Y	/, 1	998
		30. Neme end addrass of person					MITCH	ID C	MD 0170	27		
	tate	ALAN CARROLL 31. Dele filed (Month, Day, Year)		gistrar's Signetur	TON A	VE., EM	INT 12R	KU,	MD. 2172			
Regis		JAN 0		alia David	sor Ra	Let						
		51111			100	Acres à						

- Cara A Chillenn

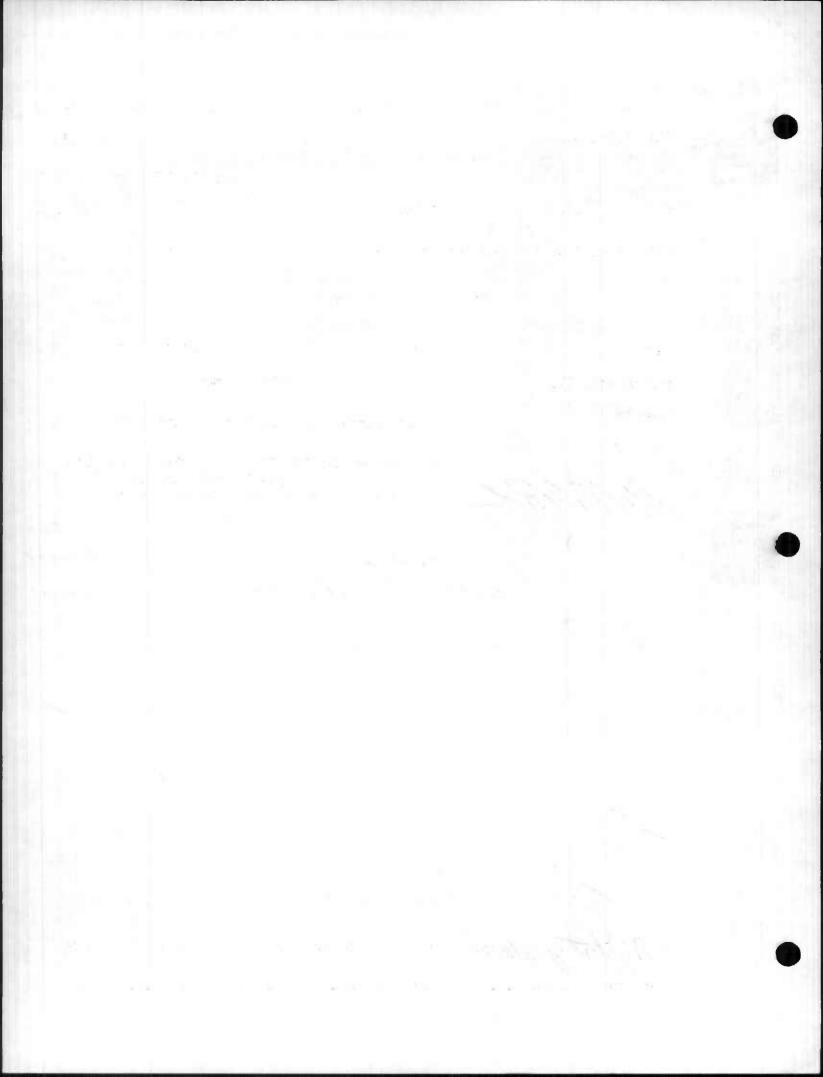
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State of Maryland / Department of Health and Mental Hygiene 8 0 2 5 2	7
0-416-4 60-41	

	-						Cert	ificat	e of	Death			Reg. No		J has W	
Dhysisian		1. Decedent's Name (First, Midd	lle, Last)								2. Date of De				Time of Death
Physician /Medical	_	WILMER JACOB O	BERE	HOLZER								Janus		7 9	8	3:55a·m
Examiner	_	4a. Facility Name (If not institution	on, give	street and number	er)					4b. City, Tow	vn, or L	ocation of Deat	th 4c.	County of De	eath	
		Washington Cou	nty	Hospita.	l					Hag	gers	town		Wash	ingt	on
Funeral Director	-	5. Social Security Number 215–14–2893 Usual Residence of Decedent	6. Se	× 7 3M 2□ F	Aga (In yrs			If Undar Months	1 Yaar Days	If Under 2 Hours	Min.	8. Date of Bi	1920	9. 8	Birthplace Country)	(State or Foreign ryland
N ==	-	10a. Stata 10b. County	y		10c. C	ity, Town	or Loca	ation							10d. lr	nside City Limits
be notified at	2		Wash	ington						gersto	wn				1.	Yes 2□No
or items 23a or 2 insper must be n Funeral Dir		32 South Locus	t St	reet				10f. Zip	Code	21740)		10g. Citi	zen of What	Country? USA	
0	2	11. Marital Status 1 □ Never Married 2 Mai 3 □ Widowed 4 □ Divorced		12. Was Decede Armed Force 1 ☐ Yes 22 If Yes, Give Year or Date:	s? No	J,S.		as Deced Yes, spec		Ilspanic Orig an, Mexican, Specify:	in? (Sp , Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ar Black, Wi Specify:		
it, the Medical Exa Completed by		15. Deceder (Specify only higher	nt's Edu	cetion		16a.	Decede	ent's Usua	al Occup	ation during most	of work	ina	16b. Ki	nd of Busines	ss/Industry	/
	1	Elementery/Secondary (0-12)	ssi grad	College (1-4c	or 5+)		life. DO	O NOT us	se retired	d)	OF WORK	ing				
7 is marked other than traumatic event, the M To Be Comp	5			2			Shi	lppir	ng C	lerk			Sand	blasti	ng E	quip Man
marked other ther	5	17. Fathar's Name (First, Middle										e (First, Middle		Sumame)		
s marke aumatic	2	Aaron Oberholz	er							Vall	.1e	Barkdol	-1			
E E		19a, Informant's Name/Relation				19b.	Mailing	Address	(Street	and Number	r or Rur	al Route Numb	er, City o	r Town, State	, Zip Code	e)
other tr		Lorraine B. Ob	erhc	olzer, W						st Str	eet	, Hager	stow	m, Mar	ylan	d 21740
ry or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (5			ta	Place of cemeter, unta	, crema	atory or o	thar plac	etery	J	an. 20		pshurg		
important: any injury once.		21. Signature of Funeral Service	Licens	Lou	nka)						uneral			MD.	21742
	+	23a. Part1. Enter the disease, o shock, or heart failure. Lis	r compli	ications that caus	ed the dea								_	LUCOWI	App	roximata
sician	1	snock, or neart failure. Lis	t only or				_					- 1			Inter	rvel Between at and Death
ledical	1	Immediate Cause (Final		Ac	ute	K	er	Dir	127	tory		Fail v	MP		10	minutes
miner	1	disease or condition resulting In death)		110	Duo to /	05.00.00	(0000 06		1		411			1	
<u></u>	5			Ria	1. +	1] 1	DA W	101	100	PIA	01)	moni	1		24	1 man V.
physician and sthe burial-transit		Seguentially list conditions	C 1	1119	Dua to (onsague	9		1 10		VICOVIT	<i>-</i>		~ '	- weeks
ial-tr		if any, leading to immediate cause. Enter Underlying		Chro		~1	1	cti	100	Pulm	ON.	onv (11000	se	15	Vanne
physicie as the bur	3	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	9	Chro		or as a co			• •	VUI		aly D	1300	lie	17	years
E 0 2	3	resulting in daath) Last	L,	Bro	nel										15	years
d for		Part II. Other significant conditi	ona con	tributing to death	but not re	sulting in	the und	terlying o	auea ah	en in Part I	_	22h Did	toharto	uee contribu	de to the	cause of death?
igned by the attend be detached for us by Physician/		The second secon	ona con	thouting to death	- Dut not re-	sulling in	the und	Jerrynig C	euse giv	en ur raiti.						4 Unknown
been s should												24a. Was	an autor ormed?	osy 24t	available	utopsy findings e prior to ion of cause ?
pege 2												1 🗆	Yes 2	JNo.	1 □ Yes	2□ No
E 5 0		25. Was cese referred Minedica	al l		/					26 Place	of Deet	h (Check only			1 1 100	20110
I direct		examiner?	-	lospital:	tient 2	ER/Out	nationt	3 DC	Oth	er.		me 5 Resi		S DOther /Sr	naciha)	
		27. Manner of Death		28a. Date of Ir	niury	28b. Ti	ime of	-	8c. Injur Wor		onig He	28d. Describe			Jecity)	
otor: After by the funer of the funer fication:		1 Natural 5 Pendii 2 Accident invest	ng igation	(Month, E	Say Year)	In	jury	М		k? Yes 2⊡N	lo					
al Director: After the line by the funeral Certification:		3 Suicide 6 Could determ	not be	28e. Place of l building,	njury - At h etc. (Speci	nome, far	m, stree	et, factory	, office			28f. Location (City or To	Street an wn, State	d Number or)	Ru <i>ral R</i> ou	te Number,
		29a. Certifier 1 Certifyli	ng Phys	alcian: To the bes	t of my kno	owledge,	death o	occurred	at the tin	na, date and	place.	and due to the	cause(s)	and manner	as stated.	
pletely fi		(Check only 2 Medical one)	Examir	ner: On the basis and manner	of examina	ation and	or inves	stigation,	in my o	pinlon, death	occur	red at the time,	data and	place, and d	ue to the	cause(s)
omp Me		29b. Signatura and title of partific	ar					290	. Licans	e number			29d. Dat	a signad (Mo	nth, Day,	Year)
		DAG. TR	111	YIN Por	Ane	120	. 1/1.	1	1	NAIL	21	50	_		17	1000
	-	Name and address of account	w	molested at the	doct	MIN	MHC	ian		JU T.	2-	57	10	nuary	11,	1748
	1	Name end address of person	who co	I LL CO	D +	m 23a) (1	ype, Pr	(int)		Was	14-7	own,	MI	217	11/2	
		31. Date filed (Month, Day, Year,	1	1737	1010	ma	c 1	TVE		rande	121	own,	LLa	0-11	71	
State Registrar		I AN O		IQQ D	1.1: 1	ature	- 30	2.00	-	V						

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State of Maryland / Department of Health and Mental Hygiene 8 0 2 5 2

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	Physic /Medi		Decedent's Neme Jan	nes			Pet	rello)			2. Dete of D Month January	Day	19	Year 98		e of Death
	Exami		4a. Fecility Neme (If I	AND THE RESERVE AND THE RESERVE AND THE	e street end n	um <i>ber)</i>					wn, or Lon	ocation of Dee		County o	of Deeth Se Geo	orge	's
	Funeral Director		5. Sociel Security Nur 578-14-892 Usuel Residence of D	29	Sex M 2□F		yrs. lest birthdey) 81 Yrs.	If Under Months	r 1 Yeer Deys		24 Hrs. Min.	8. Date of 8 (Month, D		916			ote or Foreign
Maryland	H show	tor		10b. County P.G.		100	City, Town or Lo								10		e City Limits
n with the	3a or 28a	Funeral Director	10e. Street end Numb 9211 Stua		(Marin	ner He	alth Car	10f. Zip					10g. Citiz		Thet Count		
5-0020 72 hours after death with the Maryland	ilena. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	11. Marital Status 1 Never Merries 3 Widowed 4		Armed F	2 XNo		Was Decedif Yes, spe			gin? (Sp n, Puerto	ecify Yes or N Rican, etc.)		Bleck	- America K, White, e	etc.	١,
	Hyglena. Wher than "natur ant, the Med cal	Completed	(Specify Elementary/Second	5. Decedent's Education of the state of the	de completed	(1-4or 5+)	(Give	DO NOT u	rk done	durina mos	t of work	ing	16b. Kin		siness/Ind		
yland yld be file	e d a	To Be	17. Fether's Name (F Anthony I									e (First, Middle Brance		Su <i>m</i> eme	9)		
e .	27 is r trau		19e. Informent's Nam James Bas		Type, Print)							e <i>l Route N</i> um Largo,				-	
Baltimore,	Department of heart Important: If item 2; any injury or other once.		20e. Method of Dispo 1 Burial 25 4 Donation 5	Cremation 3 ☐ ☐ Other (Specif	y)	State		natory or on natory 2. Name er	y Ja nd Addre	n 20,	Lee :	8 Funera ad, Cl	Cli 1 Home	nton e,In		ylan 33 C	nd
//	nding physician and leading sylvanie and sylvanie an	Physician/Medical Examiner	Immediate Ceuse (Fi disease or condition resulting in death) Sequentially list cond if eny, leading to immediate. Enter Underly Ceuse (Disease or In that initiated events resulting in death) Le	litions, lediate ving jury	ebd	Nul Due t	o (or es e consec	Quence of):	Bul	tus u	lie	<i>a</i> ,			yh.	Kr	now!
_	by the attentached for u	ysiciar	Pert II. Other signific	ent conditione c	ontributing to	death but not	resulting in the u	inderlying o	euse gi	ven in Pert I		23b. Did	d tobacco e	use con	tribute to	the cau	se of deeth?
DIVISION OT VITAL RECORDS, P.O. Bo for Attanding Physician: The law requires thet the death	has been signed je 2 should be de	Completed by Ph										24e. We	Yes 2	sy	24b. Wei eve com of d	re eutop	of cause
OT VITAL	certific irector,	To Be C	25. Wes case referred exeminer?		Hospitel:	Inpatient :	2 □ ER/Outpatle	nt 3D DO	Oti	her:		h (Check only	one)				20140
Attanding Phy	Aftar the		27. Menner, arDeeth 1						No	Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number of Rur			Vum <i>ber</i> ,				
Hospital or	within 24 nous ever used. To the Funeral Director: completely filled in by the	edicai Cert							me, date en	d place,	City or Town, State) lace, end due to the ceuse(s) end menner es stated.			ea(e)			
To the l	To the Funeral Completely filled	Medi	29b. Signature end tit	~D	290	c. Licens	se number		or the thirt		signed	(Month, D					
			30. Neme end eddres Arasto		completed ceu		Item 23a) (Type, 28 South		ve.	SE #2	202 V	Vashino	ton,	D.C	. 200)32	
	Sta		31. Dete filed (Month,			Registrar's Si							,,				



riease Type of Fillit III black illuelible lilk. Assure All C	opies Are Legible.
State of Maryland / Department of Health and Men	tal Hygiene 98 02527
29 DED MED C761 7 29 09 Up Certificate of Death	Reg. No.

MARGUERITE ITEMS: #2	PROCTOR 3 PART I. 27.
	1. Decedent's Neme (
Physician /Medical	Margue
Examiner	4a Facility Neme (If no

Marquerite Bernice Proctor 4a Facility Neme (If not institution, give street and number)

PRINCE GEORGE HOSPITAL CENTER

28 PER MEO G761 7-28-98 WR.

Month Dav 8,_ JAN. 4b. City, Town, or Location of Deeth

2. Dete of Deeth

3. Time of Death

22:30PM

5. Social Security Number 577 44 2833

1. Decedent's Neme (First, Middle, Last)

CHEVERLY

1998

4c. County of Deeth

PRINCE GEORGE

Funeral Director

9

'natural' nd Mental marked or

Pages 1 and 2 nent of Health a int: If them 27 is

Maryland 21215-0020

Saltimore,

Division of Vital Records. P.O. Box 68760.

Attending

6

24 hours a Hospital

To the Hosp within 24 hor To the Fune completely fi

Physician Examiner

burial-tran and physician the 50 use ö signed by the a à Completed been page 2 has certificate funeral director. Be Certification: To this aftar death.

1□M 2□F Usuel Residenca of Decedent 10a State 10b. County MD P.G. Directo 10e. Street end Number 7035 Allentown Road 1 Never Married 2 Married þ ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Fether's Neme (First, Middle, Last) Be Eugune Newman 19a. Informant's Name/Relationship (Type, Print) William Proctor 20e. Method of Disposition 1 ☐ Buriat 2 ☐ Cremetion 3 ☐ Removat from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee while Immediate Ceuse (Finel disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that hitleted events resulting in death) Lest Physician/Medical

If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Deys Min Hours Yrs. Sept 10, 1920 Washington DC 10d. Instde City Limits 10c. City. Town or Location 1 Yes 20 No Camp Springs 10f. Zip Code 10g. Citizen of Whet Country? 20748 United States 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates: 14. Raca - American Indien, Btack, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Native Specify: American 1 Yes 2 No Specify: 16e. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Nursing Private 18. Mother's Name (First, Middle, Maiden Sumeme) Mary Marie Savoy 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5752 Sweet Bay Court, Frederick, Md 21703 Jan 21, Date 98 20c. Location - City or Town, Stete 20b. Pleca of Disposition (Neme of cemetery, crematory or other pleca) Maryland Veterans Cemetery Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735 23e. Part f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth INFLAMMATORY BOWEL DISEASE

Due to (or es e consequence of):

Due to (or es a consequenca of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Yes 2 No 3 Probably 24a. Was an autopsy performed?

2 No

23b. Did tobacco use contribute to the causs of death?

24b. Were autopsy findings avaitable prior to completion of cause of deeth?

Yes 2 No

4 Unknown

25. Wes case referred to medical examiner? Hayes 2□ No

27. Manner of Deeth 1 X Naturet 5 Pending Investigation 2 Accident 6 Could not be determined Julcide

Hospitel: 1 ☐ Inpatient 2 ☐ EP/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work? 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how tnjury occurred

1 Yes

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only one) 29b. Signeture end title of certifier

4 Homicide

29a. Certifier

Medical

State

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one)

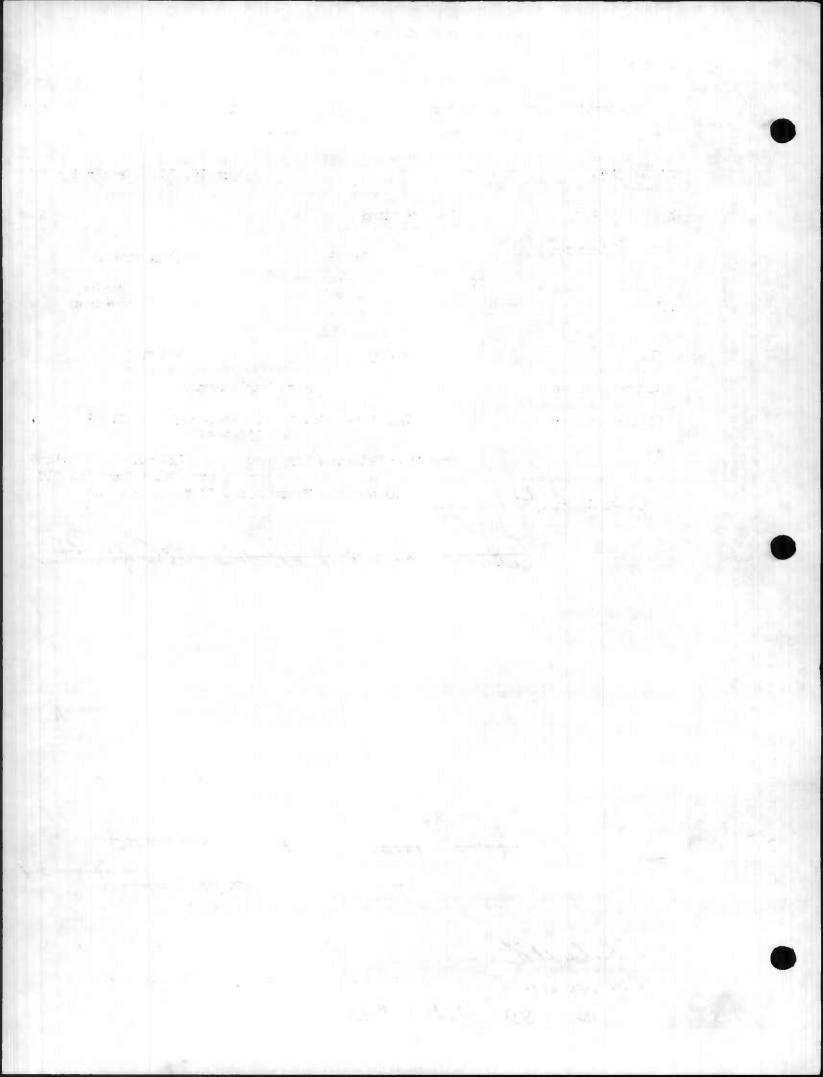
O.C.M.E

JAN. 10, 1998

30. Name and address of person who completed caused of deeth (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

HER DIPE MIFE 31. Dete filed (Month, Dey, Yeer)

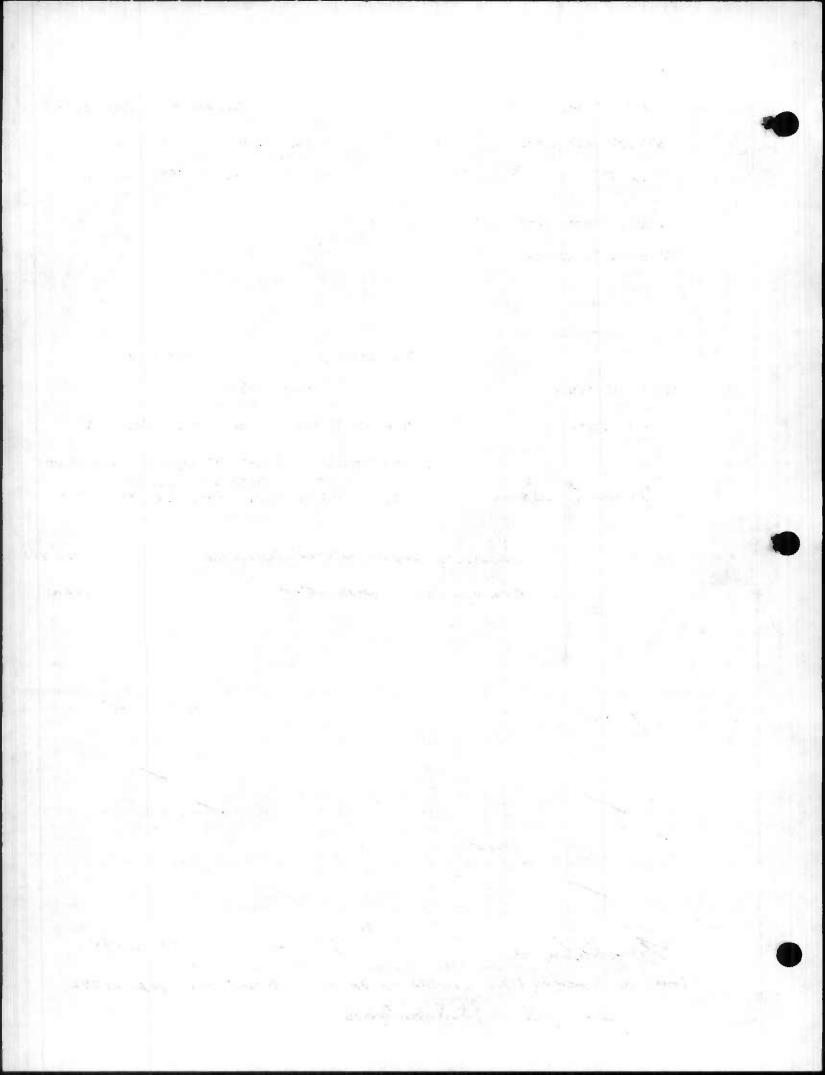
2. Registrar's Signeture Juli Stantison Revolate 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

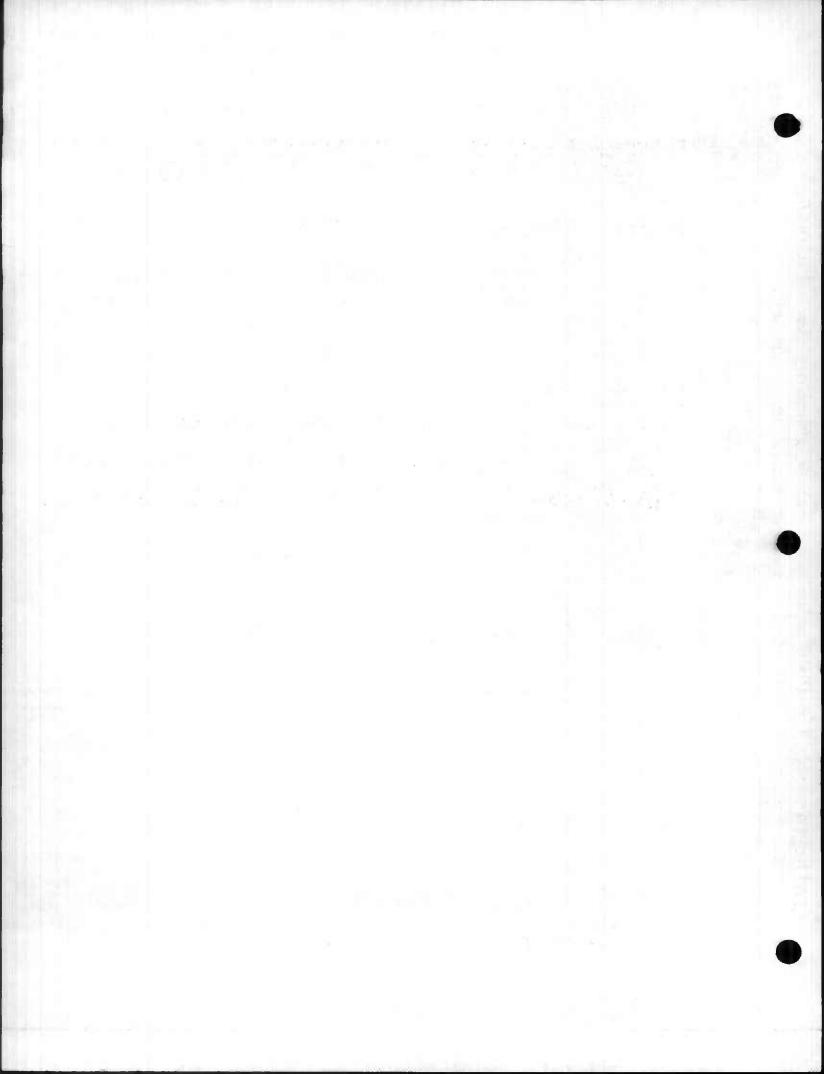
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Physici	ļạn	Alice Rebeco							Month	Day	Yaar	
/Medi				201				4b. City, Town, or	JANUAR Doot		1998	1330
Examir	ner	4a. Fecility Nama (If not institution, g		er)			- [-	nty of Death	
		334 McDowell A		A		If I land	ar 1 Year	Hagerst			shingt	
uneral irector		5. Social Security Number 6. 215-18-2732 Usuai Rasidanca of Decedant	Sax 7 1□M 2又F	81	. last birthday) Yrs.	Month		Hours Min.	8. Data of Bird (Month, Da Dec. 1	y, Year)	9. Birthp Coun Mary	laca (Stata or Fore try) land
M III		10a. Stata 10b. County		10c. C	ity, Town or Lo	cation					11	0d. Insida City Lim
Hed.	tor	Maryland Washir	ngton		Hager	stow	'n					1 Yas 2
7 28	le le	10e. Street and Number				10f. Z	ip Coda			10g. Citizan o	of What Coun	try?
23a c	alD	334 McDowell Ave	enue				217	740	7.1.1.7	U.	S.A.	
tem 27 is marked other than 'natural', or items 23s or 28a-f show other traumatic event, the Medical Examinational be notified at	by Funeral Director	11. Maritai Status 1 ☐ Navar Married 2 ☐ Married 3 ☑ Widowad 4 ☐ Divorced	12. Was Dacadar Armed Forca 1 Yas 2 If Yas, Giva Yeer or Dates	s? XNo			edant of Hoecify Cube	lispanic Origin? (S en, Maxican, Puart Specify:	pecify Yas or No o Rican, atc.)	Spec	aca - Amaric leck, White, o	
lical	Completed	15. Decedent's E	Education		16e. Deced	dent's Us	uel Occup	ation	ting	16b. Kind of	Businass/Inc	lustry
Med	ple	(Spacify only highest g Elementary/Secondary (0-12)	College (1-4o	or 5+)	life. L	DO NOT	use ratired	during most of word)	King			
ont, the M	Con	7	0		Hou	seke	eping	2		Hospi	tal	
Ven	Be (17. Fethar's Nema (First, Middla, Las	st)					18. Mothar's Nar	na (First, Middla,	Maidan Sum	ema)	
marked of	10	Maurice M. Mount						Mary Ca	therine	Krom		
arms		19a. Informant's Name/Ralationship	(Type, Print)		19b. Mailin	ng Addra	ss (Street	and Number or Ru	ıral Route Numbi	er, City or Tou	m, Stata, Zip	Coda)
em 27 i		Alice R. Potter			334	McDo	well	Avenue	Hagers	town.	Md. 21	740
oth		20a. Mathod of Disposition			Placa of Dispo cematary, cren	sition (N	ame of		Date	20c. Locatio		
y or		1 ☐ Burial 2 ☐ Cremation 3 I 4 ☐ Donation 5 ☐ Other (Space		(a					21 00	II		Managara T. a. a.
injur.		21. Signature of Funaral Sarvice Lica		Cec				al Park]				Marylan
Important: If Item 27 any Injury or other tr once.		. 1	Spicer					lson Blvd	nnich F l. Hage	uneral rstown		21740
		Immediate Occurs (Fig.)							or raspiratory a			
edical miner	ner	Immediata Causa (Final disasse or condition resulting in daeth)	a. CONGS	Due to (F HEH	AT /	CAL ():	ONE SUS			1	Onsat and Death
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Catherine G. Palmer

Catherine G. Palmer Division of Vital Records. P.O. Box 68760.

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State of Maryland / Department of Health and Mental Hygiene

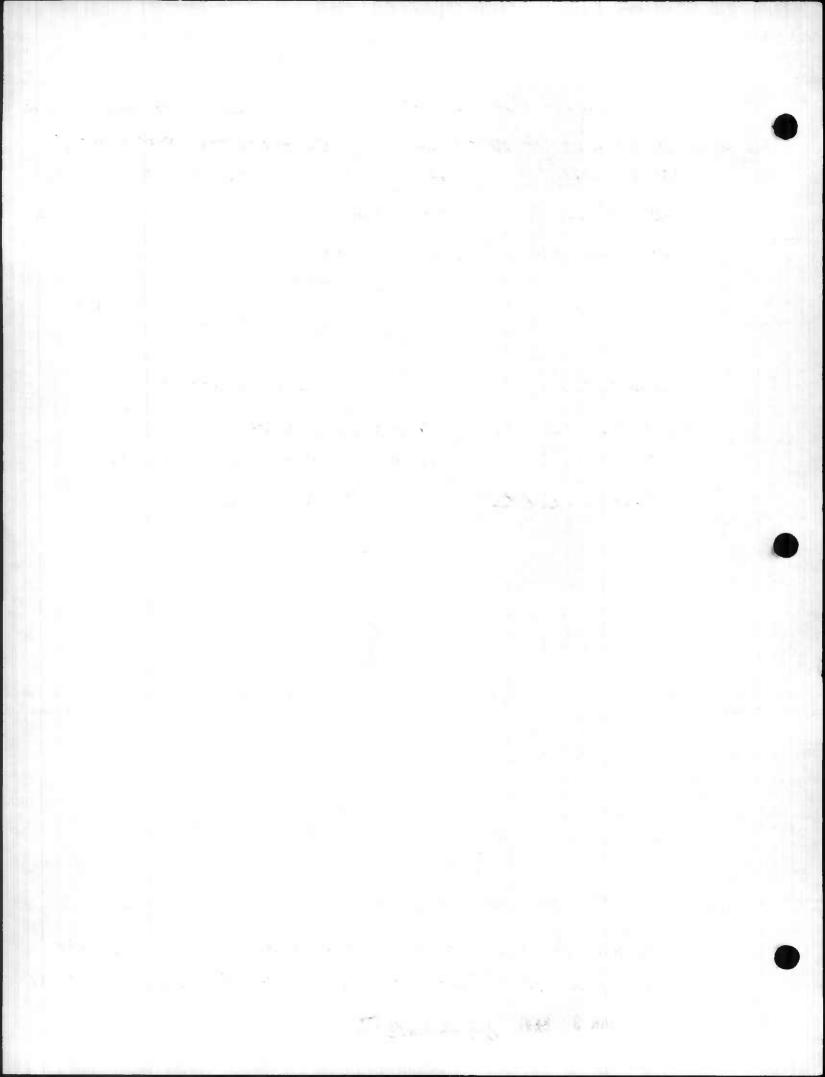
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Homer Washington Palmer January 9, 1998 9:55 P.M. /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Frederick Memorial Hospital Frederick Hours Min. 8. Dete of Birth (Month, Dey, May 12, 6. Sex 1 M 2 F If Under 1 Year 9. Birthplece (State or Foreign Country) Maryland 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** 219-12-1984 73 Yrs **Director** Usuel Rasidanca of Deceden permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene. Intropretant: If item 27 is marked other than "natural", or items 23a or 28e4 show any injury or other traumatic event, the Medical Examiner must be notified anonce. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Frederick Walkersville 10e. Street end Number 10f. Zin Code 10a. Citizen of Whet Country? 8888 Triumphant Court 21793 U.S.A. Funerai Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Security Guard Security 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Naomi Catherine Ridenour Albert Charles Palmer 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) 8888 Triumphant Court, Walkersville, Maryland 21793 Nancy L. Palmer/Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete Buriel 2 Cremetion 3 Removel from State Fred. Memorial Park 1/13 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701 acce e deeth. Do not enter the mode of dying, such as cardiec or respiretory errest Approximete interval Between Onset end Deeth RESPIRATORY TRILURE **Physician** /Medical Immediate Ceuse (Finel disease or condition rasulting in deeth) Examiner WASCULAR ACCIDENT Physician/Medical Examine CEREBRN ettending physician and for use es the burlel-trensit The lew requires that the deeth certificate be executed Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, TUMOR Due to (or es e consequence of): signed by the ed 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveileble prior to completion of causa of death? 24e. Wes en eutopsy performed? Completed certificate hes b 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this funeral 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred Certification: 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? After 1 Netural
2 Accident 5 Pending Investigation 1 □ Yes 2 □ No death. Director: / 6 ☐ Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 24 hours efter Funeral Direct pletely filled in b 4 Homicide Hospital 1 🗹 Certifying Phyeician: To tha best of my knowladga, daath occurred et the time, dete end pleca, end dua to tha causa(s) and mannar es stetad. 29a. Cartifiar edicai (Check only one) 2 Medical Exeminer: On the bests of examinetion end/or Investigetion, in my opinion, daeth occurred et the time, date end placa, end due to tha causa(s) end menner steted. within 2 To the 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Nama end addrass of person who completed cause of deeth (Itam 23a) (Type, Print) 310 West Ninth Street, Frederick, MD 21701 John A. Vitarello, MD 32. Registrer's Signature 31. Dete filed (Month, Day, Year) JAN 12 State

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical		Decedant's Nama (First, Middla, La		0	Certificate	U Deall	2. Data of E		3. Tima of E
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Department of heeling important: If Nem 27 is any injury or other tra	1	21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility							
		Hilton Funeral Home							
		Barnesville, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate							
ysician		shock, or haart failura. List only one cause on each line.						Intarval Betwo	
Medical	Examiner	Immediata Cause (Final disaase or condition	Prevmonia					3 d	
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Toth		Much April mo 047791 January 7							7,1998
within 24 hours arter death. To the Funeral Director: Aft completely filled in by the fun			complated cause of death (Itam 23a) (Type, Print) Holden us 809 Voirs Mill, Rockville us 20						
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Toth		30. Nama and addrass of person who David A.	111	ath (Itam 23a	809 VO	urs Mill	, Roc	kville	mp 208
State		30. Nama and addrass of person who David A. 31. Data filed (Month, Day, Year)	Holden 32. Ragistrar	r's Signatura	orkerlett	urs Mill	, Roc	kville	mo 208



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth **Physician** 20, Dorothy 1998 Brown January Reid 11:10PM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge | If Under 1 Yaar | If Undar 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | April 11,1905 Dorchester 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M XXF 222-07-3522 92 Yrs. Director Maryland Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Dorchester Director Maryland Cambridge XX Yas 2 □ No 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 525 Glenburn Avenue 21613 US by Funerai 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yas XXI No If Yes, Give Yeer or Detas: Wes Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 14. Race - Amarican Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X Xio Specify: White Specify: Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) Operator Telephone Company 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental John Brown Emma Blades 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a If Item 27 is or other tra Sue L. Gregory Grand Daughter P.O. Box 1847 Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State XIX Buriel 2 Cremetion 3 Ramoval from Stata permit. Page Depertment of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Dorchester Memorial Park 1/24 | Cambridge, Maryland 21. Signeture of Funerel Sarvice Licensee 22. Name and Address of Fecility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 TI 23a. Pert1 Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medicai Immadiate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or es e conseque Examiner or Attending Physician: The law requires that the death certificate be executed the bunal-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in deeth) Lest Physician/Medical Due to (or es a consequence of): for use as Pert II. Other significant conditions contributing to death but not rasulting in the undarlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? page 2 should Completed 24e. Wes en eutopsy performed? peen this certificate 1 🗆 Yes 1 ☐ Yes 2 ☐ No director, Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 ☐ Yes 20 No Other:

Jursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 27. Menner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of Aftar 5 Pending investigation 1 Neture! s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homleide

t⊞ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2☐ Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29c. Licanse number

29d. Date signed (Month, Day, Year)

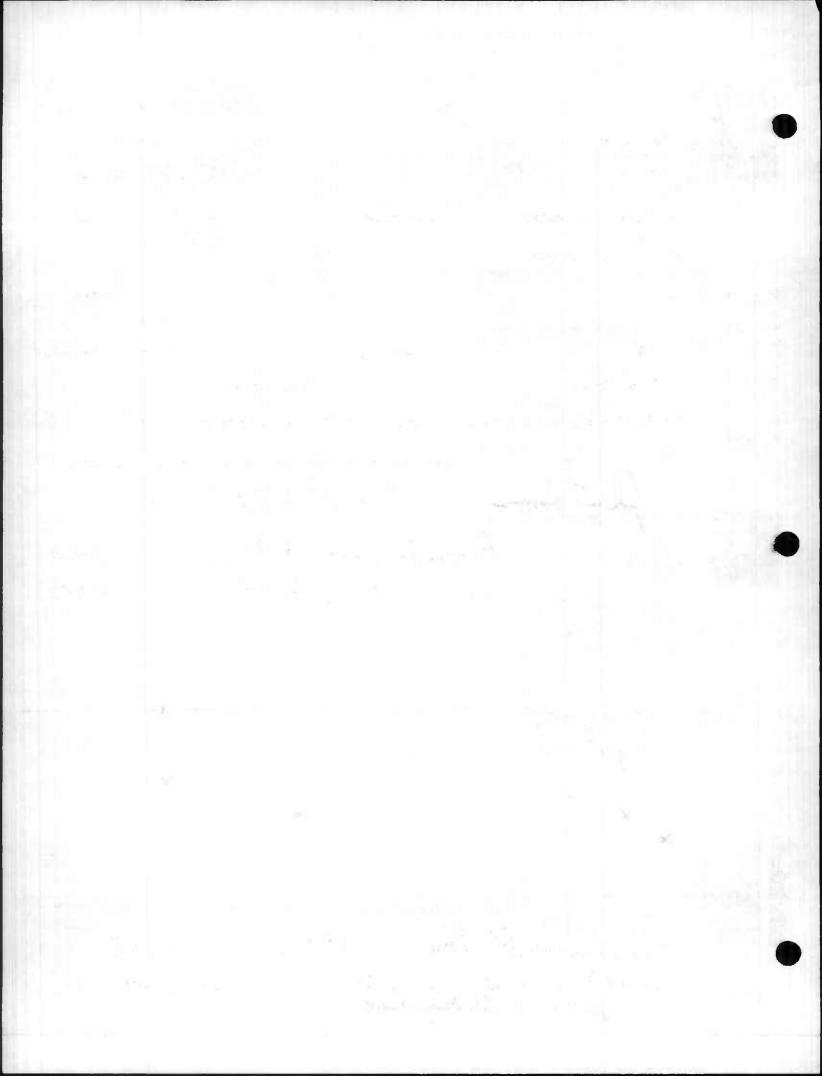
P.O. Box 68760, Records, Division of Vital To the Hospital o within 24 hours af To the Funeral DI completely filled in

> State Registrar

Medicai

29e. Certifier (Check only one)

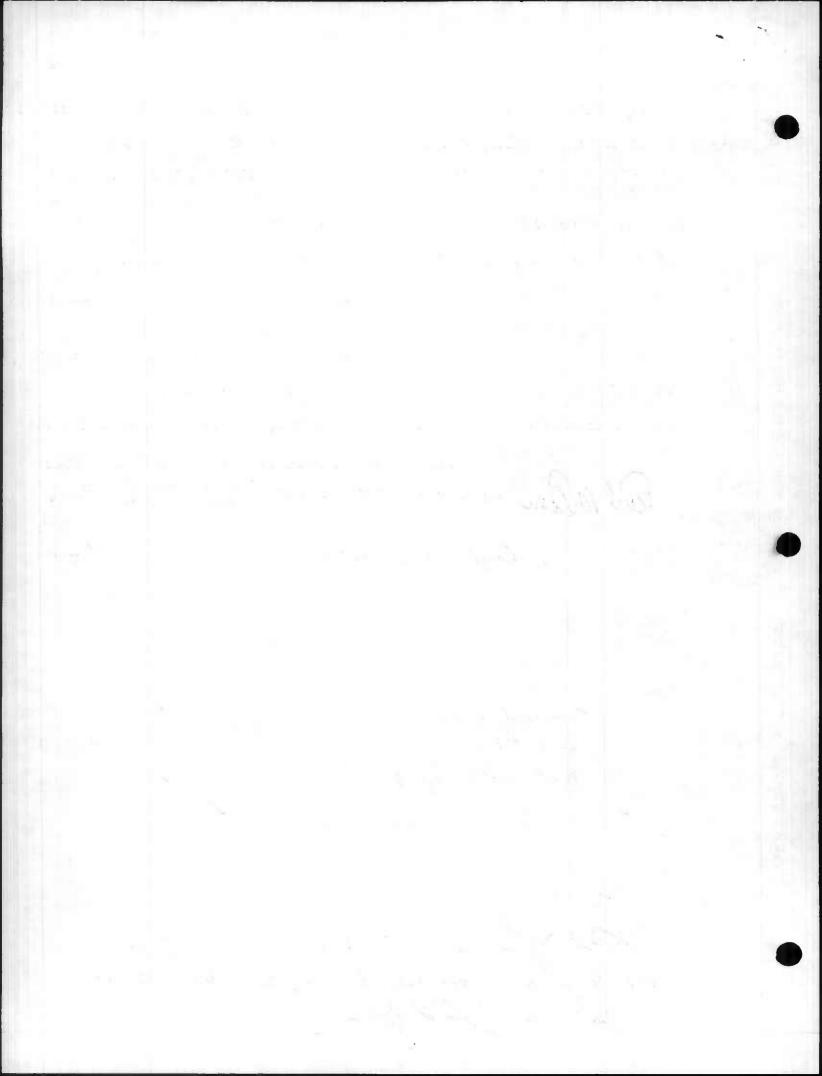
29b. Signeture and title of certifier



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Physician EARL MELVIN RUBECK JANUARY 18 1998 11:10 PM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 11 WEST BALTIMORE STREET, APT. 108 HAGERSTOWN WASHINGTON If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2□ F Months Deys Yrs. 220-26-5724 Director 74 JULY 16, 1923 MARYLAND Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow r than "natural", or Items 23a or 28a-f ahov The Medical Examiner must be notified at Director 1 Yes 2 □ No MARYLAND WASHINGTON HAGERSTOWN 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Med call Examinest must be a 11 WEST BALTIMORE ST., APT. 108 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo If Yes, Give Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status 1 ☐ Never Married 2 X Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Divorced WHITE Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 6 CLOTHING MANUFACTURE MAINTENANCE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be NATHAN HOWARD RUBECK 2 CORA ARETTA KNABLE 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MABEL V. RUBECK/WIFE 11 W. BALTIMORE ST., APT. 108, HAGERSTOWN, MD 21740 Baltimore, 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) SAMPLES MANOR CEMETERY 1/21/98 SHARPSBURG, MARYLAND 21. Signeture of Runerel Service Incensee 22. Name end Address of Fecility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23e. Per11. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer feilure. List only one ceuse on eech line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final 1 year disease or condition resulting in deeth) **Examiner** Examine The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Lest and Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yas 2 No 3 Probably 4 Unknown Cardiorenal syndrone . þ Completed Real Faitin 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of death? 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No certificate I or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours af To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end manner stated. Medicai 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 26579 Mul 30. Neme end eddress of person who ampleted cause of death (Item 23e) (Type, Print) Hagestown, 21742 R.L. / Turler 747 Norther due, ms 31. Dete filed (Month, Dey, Year) 32. Regi State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death * Month **Physician** 16:43 Lucy May Rohrer anuary /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 8. Dete of Birth Nov • 23, 1926 9. Birthplece (Stete or Foreign Country) Mary I and 7. Age (In yrs. lest birthday) **Funeral** Deys 1□M 2×F Months 71 Yrs. 219-20-1836 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits Yes 2 No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 11 W. Baltimore Street 21740 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after near of Healin and Mental Hygiene. Intel of Healin and Mental Hygiene. If Item 27 is marked other than "natural", or the iny or other traumatic event, Its Mental Entities iny or other traumatic event, Its Mental Institute. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify:White Be Completed by 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) 8 Housewife Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Edward Young 2 Florence Elizabeth Sharer 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zlp Code) Philip H. Rohrer Jr./Son 11845 White Hall Road Smithsburg, MD 21783 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any injury or Cedar Lawm Memorial Park 1-20-98 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Ligens Osborne funerally Home 425 S. Conococheague St. Williamsport, MD 21795 Approximete Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** week /Medicai Immediete Ceuse (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or trijury that initieted events resulting in death) Lest Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? page 2 should 24e. Wes en eutopsy 2 No 1 Tyes 2 No funeral director. 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 30 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation Naturel death. 2 Accident 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homiclde

Attending Physician: within 24 hours effer death.

To the Funeral Director: A completely filled in by the fo ò Hospital

> State Registrar

Medical

29a. Certifier (Check only one)

29b. Signeture end title of cartifier

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

14 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end placa, end due to the ceuse(s) end menner es steted.

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) ROAL

D26523

Dino J. Delaportas, M.D.

31. Dete filed (Month, Day,

32. Registrar's Signeture

Irlia Davidson

Spirit State of the state of th Solution for the same and the same for the same point and safety president planskip profit in the rest of the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth William . REILLY Jan.

Physician /Medical Examiner

Director

Funeral

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Completed

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Funeral

Director r than "natural", or items 23a or 28a-f show the Mudical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Introduction: if item 27 is marked other than "natural, or item any injury or other traumatic event, it witch item any injury or other traumatic event, it witch item and item. Baltimore, Maryland 21215-0020

Box 68760, Vital Records, P.O.

Physician /Medical Examiner Physician/Medical Examiner by Completed Be Certification: To 24 hours Funeral Medical within 2

Garnet 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Hagerstown Washington Washington County Hospital If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year)
May 13,1921 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Deys Months 1⊠M 2□ F Hours Yrs 76 Pennsylvania 204-03-5685 Usual Residence of Decedent 10e. State 10c. City, Town or Locetion 10b. County 10d. Inside City Limits ¥Q¥es 2□No Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 622 George Street 21740 U.S.A. 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 A Yes 2 No
If Yes, Give W.W.II
Year or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2X No white Specify: Specify: 3 Nidowed 4 Divorced Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) loader operator paving company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) William Frank Reilly Mary Catherine Ridgely 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mrs. Linda Ragland/Daughter 622 George Street, Hagerstown, Maryland 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1

■ Burial 2 □ Cremetion 3 □ Removel from State Jan. 20,1998 Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name end Address of Fecility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert teilure. List only one ceuse on eech line. Approximete Intervai Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) cancer metastatic to liver 1 month Due to (or es e consequença of) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events Due to (or es e consequence of): thet Initieted events resulting in death) Lest Due to (or es e consequença of): 23b. Did tobacco use contributa to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 740

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 ER/Outpetient 3 DOA 27. Manner of Deeth Natural 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 - No 2 Accident 6 Could not be determined 3 Suicide Piaca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier

time Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end ptaca, and due to the cause(s) end menner steted. (Check only one) 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Dev. Yeer)

30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print)

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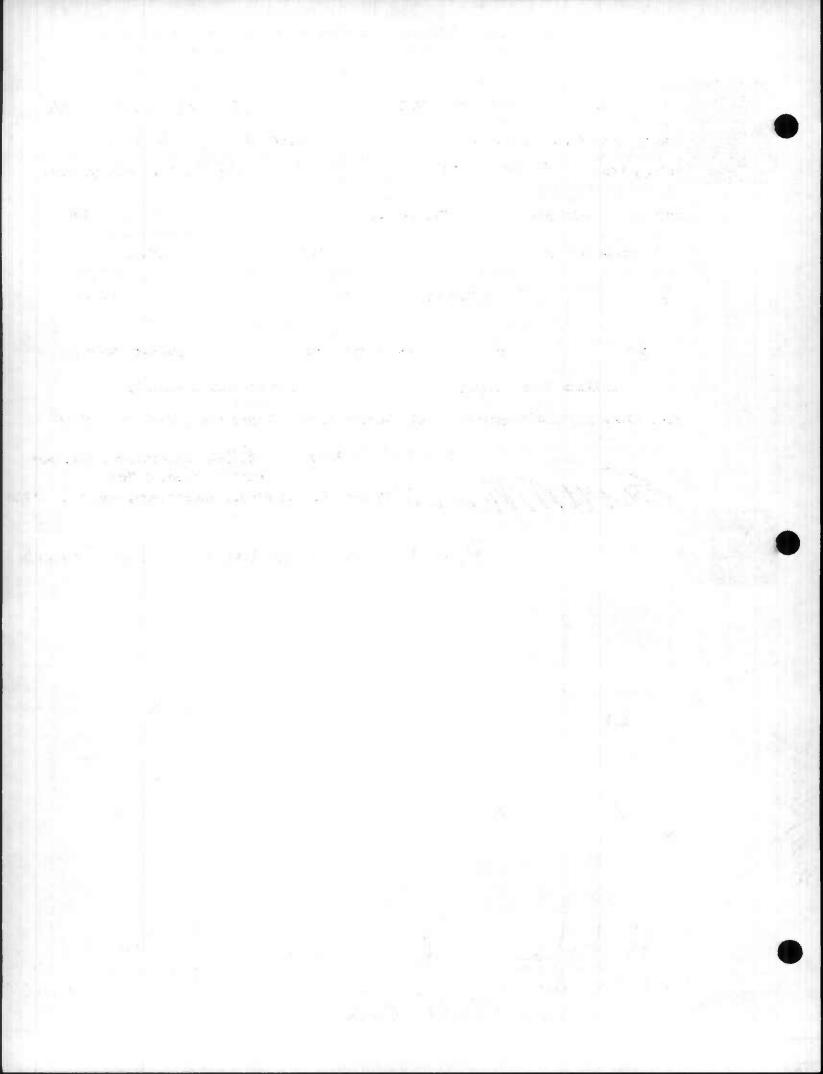
filed (Month, Day, Year)

Hagerstow

3 Probably 4 Unknown

State Registrar

MI 363 32. Regista Signature S



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Robert Glen Reid January 10, 1998 11:21 AM 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Frederick If Under 24 Hrs. Hours Min. Min Frederick Memorial Hospital If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 6 Sev 7. Age (In yrs. last birthday) 15M 20 F Months Days 82 Yrs 197-03-1695 1915 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 XYes 2 No 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 1001 Carroll Parkway 21701 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien Bleck, White, etc. 1 Ryes 2 No If Yes, Give 1943 to Yeer or Dates 1944 to 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Specify 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation 16e. Decedent's Usuel Occupation 16e. Decedent's Usuel Occupation 16e. Decedent's Usuel Occupation 15. Decadent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Engineer 12 Sterilizing Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) James Herbert Reid Ruth Anna Evans 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy E. Reid/Wife 1001 Carroll Parkway, Frederick, MD 21701 20b. Pleca of Disposition (Neme of 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State Smithsburg Crematory Jan. 12, 1998 Smithsburg, MD. 4 Donetion 5 Other (Specify) 21. Signalus of Funeral Service Licans 22. Neme end Address of Fecility Keeney & Basford Funeral Home 26 M00021 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiratory errest, Approximate Approximate Approximete Intervel Between Onset end Death roscleratic Vecsel Disease Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1□Yes 2/1No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24e. Was en eutopsy performed? completion of cause of deeth? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) exeminer? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 D ER/Outpetient 3 ☐ DOA 28a. Date of injury (Month, Dev Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 Yes 2 No

Examiner certificete be axecuted physician end the burial-tran Box 68760 80 esn jo signed by the e Records, P.O. peed s paga 2 has cartificate Division of Vital funeral director, this After or Attending after death. Director: After

Physician

/Medical

Examiner

Director

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Completed

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Funeral

Director

/ Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

pemit. Pages 1 end 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or any injury or other treumetic event, the Medical Example.

Physician

/Medical

Examiner

the Maryland

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death

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Baltimore, Maryland 21215-0020

Physiclan/Medical þ Completed Be ဂ Certification:

27. Menner of Deeth 1 Neturel 2 Accident 3 Suicide

29a. Certifier (Check only one)

4 Homicide

investigation 6 Could not be determined

28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

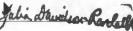
Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. 29b. Signety? and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

MI s of person who completed cause of death (Item 23a) Type, Print ten 610

31. Date filed (Month, Dey, Year)

32. Registrer's Signature



completely filled in by

Medical

State Registrar

To the Hospital owithin 24 hours at To the Funeral D

AND THE RESIDENCE

		1. Decede	nt's Neme	e (First, Mide	die, Las	t)						Death	2.	Dete of Dee			3. Time of Deer
Physici /Medic		D	avid	F	Rau								Ja	Month Inuary	7, 19	998	6:43
Examin		4e. Fecility	Nema (II	f not instituti	ion, give	street and	number)					4b. City, Tow	n, or Locat	on of Deeth	4c. Cou	nty of Deeth	
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uneral irector			14-59	919	6. Sa	x M 2□ F			lest birthday Yrs.	Month	der 1 Year is Deys		Min.	Dete of Birt (Month, De	1927		plece (Stete or For ntry) sylvania
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month CHARLES R. SCHNEIDER 4.30 am Jan, 17 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 2451 Huntingfields Drive (RESIDENCE) Huntingtown Calvert If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Feb 22, 1921 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) XX M 2□ F 220-34-8504 76 Canada Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2451 Huntingfields Drive 20639 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. Black, White, etc. YM Yes 2 No If Yes, Give Year or Dates: W.W.II 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner / Operator Schneider's Nursery 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Schneider Mary Leffett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline R. Schneider (WIFE) 2451 Huntingfields Drive, Huntingtown, Md 20639 20b. Place of Disposition (Name of cemetery, cremetory or other place) Jan 19 Data 1998 20c. Location - City or Town, State 20a. Method of Disposition Weburial 2 ☐ Cremation 3 ☐ Removal from State Southern Memorial Gardens 4 ☐ Donetion 5 ☐ Other (Specify) Dunkirk, Maryland 22. Name and Address of Facility Lee Funeral Home, Calvert P.A. 21. Signature of Funeral Ser 1825 Southern Maryland Blvd. Owings, Md 20736 23a Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death · CARCINUMA Due to (or as a consequence of). DISERSE Few years PULMONARY OBSTRULIVE CHRONIL Due to (or es e consequence of) Due to (or es e consequence of): 23b. Dld tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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signed by the

page 2 s

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After

Director: /

within 24 hours a

To the Funaral C

completely filled

director

Hospital or Attending Physician: 24 hours after death.

To the

The law requires that the death certificate be executed

Box 68760

P.O. |

Records,

Division of Vital

Physician

/Medicai

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

death

within 72 hours aftar

Hygiena.

permit. Pages 1 and 2 should be file. Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic eventable.

altimore, Maryland 21215-0020

Director

Funeral

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Completed

Examiner Physician/Medicai by Completed Be

Immediete Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 D Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and menner stated. edicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) patel/MD D 50249

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PR. FREDERIUK

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State Registrar 31. Date filed (Month, Day, Year)

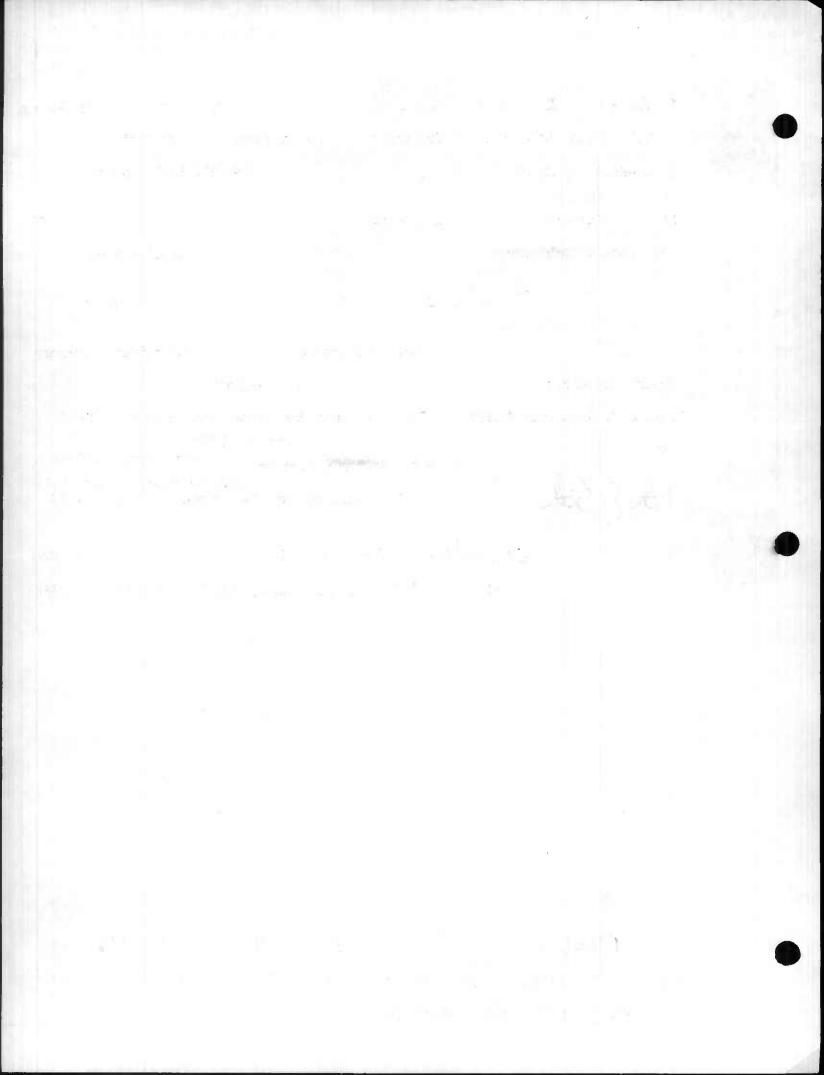
PRANAY

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30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

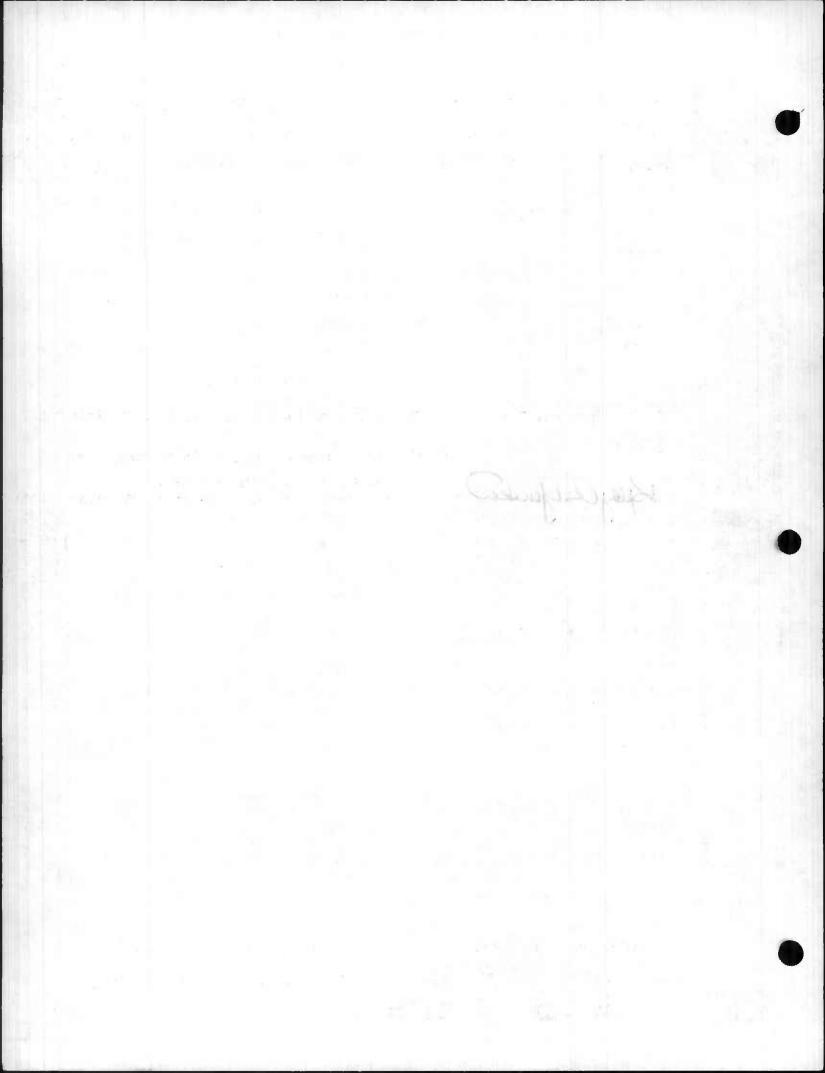
PATEL

110 HOSP. RD 32. Begistrer's Signature



State of Maryland / Department of Health and Mental Hygiene 8 0 2 5 3 9

		5					Cen	tificat	e of	Death			Reg. No.		
	Physic /Medi		Decedent's Neme (First, Mid- MINNIE IRENE :		R	•						2. Dete of D Januar		, 199 8 °	3. Time of Deeth 1:26 p.m
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	Funeral Director		5. Sociel Security Number 578–34–0700	6. Sex 1 □ M 2	7. Age	(In yrs. last birt	thdey) Yrs.	if Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Date of B Month D June 6	irth ey, 1965	9. Bir	thplece (State or Foreign Virginia
	a-f show	tor	Usuel Residence of Decedent 10a. Stete 10b. Count MD	v Vashingt	on	10c. City, Town	or Loc	ation	Н	agerst	cown				10d. inside City Limits 12 Yes 2 No
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21215-0020	within 72 ho ene. than "netur he Wedical	Completed	15. Decede (Specify only high Elementery/Secondary (0-12)		ted) 9e (1-4or 5+		(Give k	O NOT us	k done e retire	during mosi	t of work	ing	16b. Kin	d of Business	
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Balt	Department Important: If any injury of any i		21. Signeture of Funeral Service	Licensee	En))						Funeral			ryland 21740
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			30. Name end eddress of Person MAN2AR.	J SHX	cause by dee	oth (Item 23e) (T 368 M/L	Type, P	rint) STRE	ET	HAC	RER	STOWN	191	0 217	42.
113	Sta	te	31. Dete filed (Month, Dey, Year,	1 4000	2. Reginan	a Signature		-							



State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 2135 Lena Liza SISK 1998 January 20 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Hagerstown

If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) Washington County Hospital Washington 5. Social Sacurity Number Birthplaca (State or Foreign Country) 6. Sax 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□ F Yrs. Director 84 220-10-3601 Feb. 2 1913 Maryland Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "natural", or items 23s or 28s-f shov traumstic event, the Medical Examinat must be indiffed at Director 1 ☐ Yas 2 ☑ No Maryland Washington Boonsboro 10a. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 141 S. Main Street death 21713 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Rece - Amarican Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0020 1 ☐ Yas 2 ☒ No Specify: Completed by Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry I Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) Laundry Worker Unknown Unknown Hospital Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Pagas 1 and 2 should be finant of Haaith and Mantal I inter 27 is marked or William Shank Annie Shinendigger 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) other Martin L. Bowers - Nephew 7738 Desmond Ave. North Charleston, S.C. 29418 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Rose Hill Cemetery 1-23-98 | Hagerstown, Maryland 21. Signature of Funeral Service Licensee Name and Address of Fecility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line. Approximete Intervei Between Onset end Deeth HYPOVOLUMIC SHOCK

Due to (or es e consequenca of):

CASTRO INTESTIMAL BLEEDING

Due to (or es e consequence of):

USEASE **Physician** /Medicai Immediate Ceuse (Final diseese or condition resulting in death) Examiner Examiner The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest P.O. Box 68760. Physician/Medicai the Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco uea contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 9 Completed 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? certificata 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: T s aftar death. I Director: After this certificat funaral director. 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigetion 1 Naturei 1 ☐ Yes 2 ☐ No 2 Accident tha 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. To the Hospi within 24 hou To the Funer completely fil Medical 29a. Certifier 39d. Deta signed (Month, Dey, Year) Jan 20, 1998 29b. Signature end title of certifier 29c. Licanse number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2NPM MALK 203// LAPPANS Ro Rosassloro MP. 21713

DHMH 16 Rev 6/95

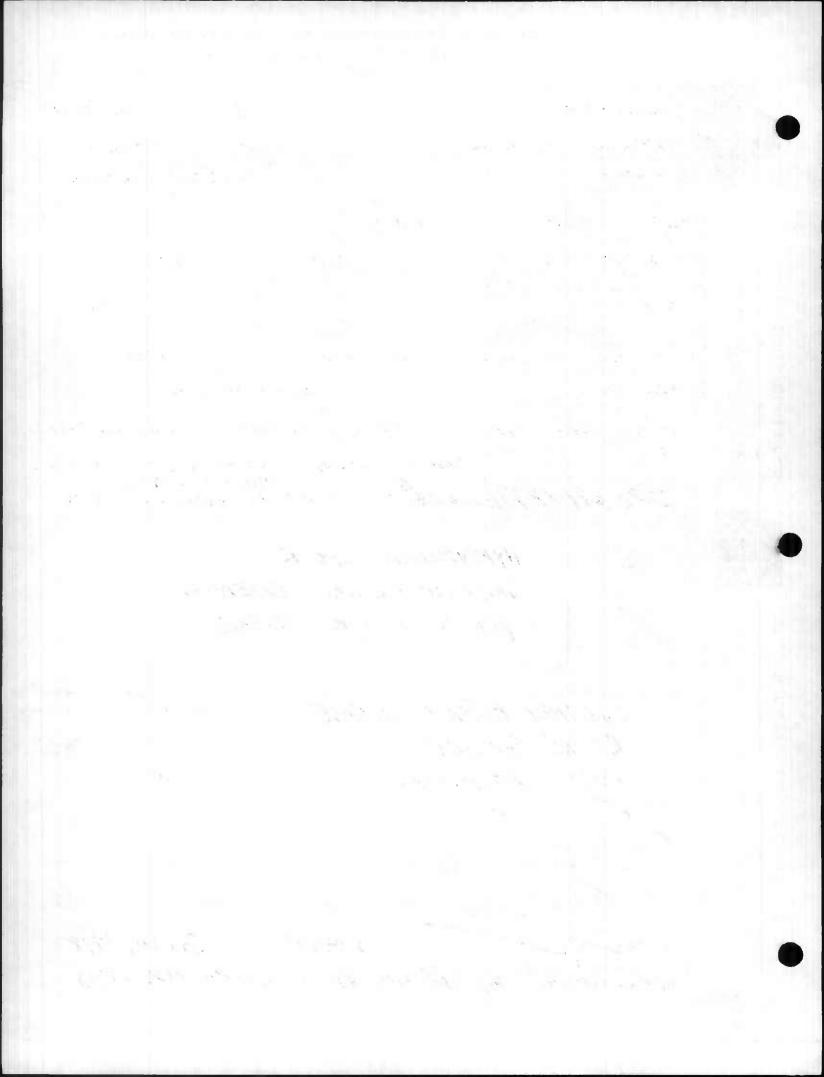
State

Registrar

31. Dete filed (Month, Day, Year)

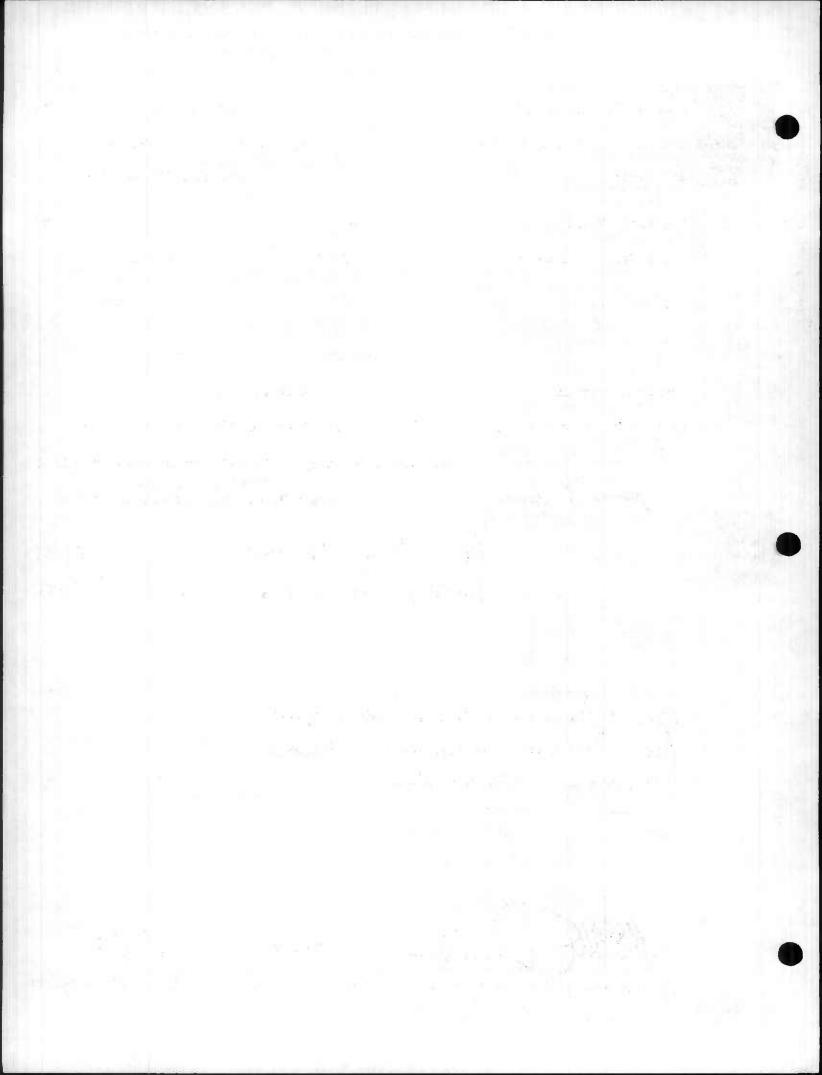
JAN 2 2 1998

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 02541 Certificate of Death

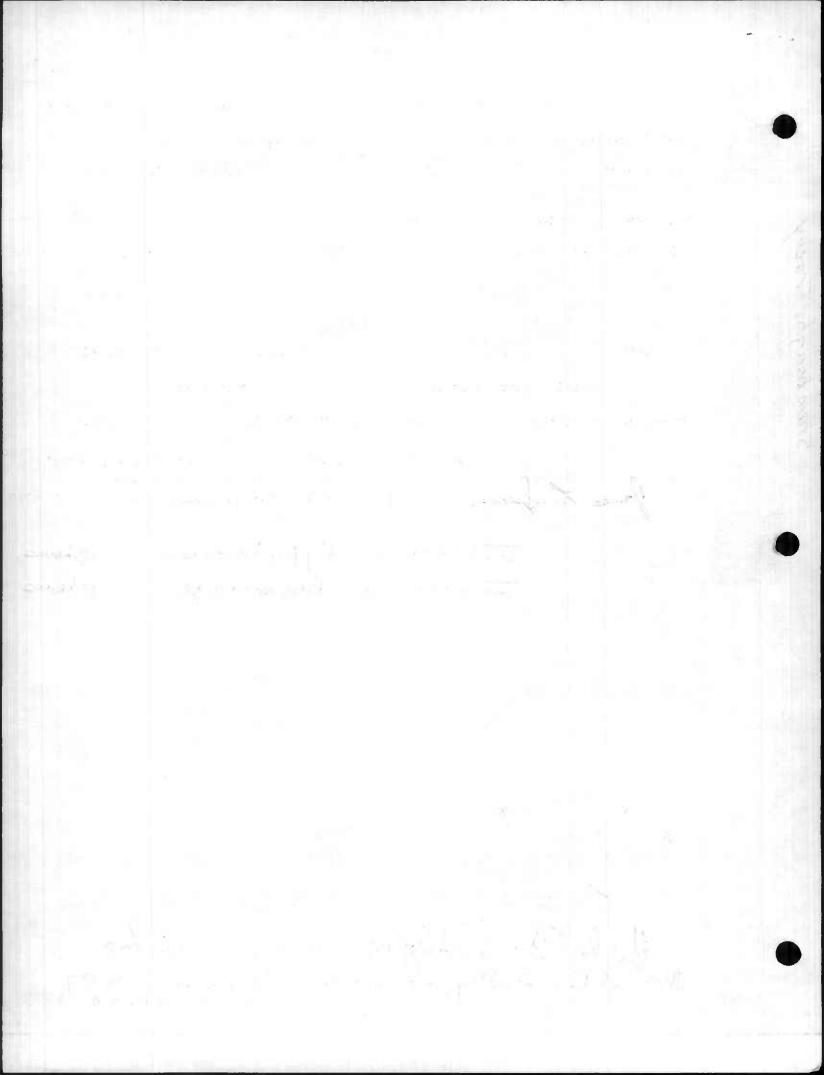
						001	imouto o	Douth			Reg. No.		
	Physic	ian	Decedent's Name (First, Middle, La			- 11				2. Date of D Month	Day	Year	3. Time of Deeth
	/Medi	cal	Mary Virginia S					1		Januar	7	1998	11.34 01
	Exami	ner	4a. Facility Name (If not institution, giv					4b. City, To	own, or L	ocation of Dea	th 4c. Coun	ty of Death	1
		Ш	Washington Coun					Hage				hingt	
	Funeral		Social Security Number 6. S	ex 7. □M 2DXF	Age (In yrs. lest b		If Under 1 Yes Months Day		24 Hrs. Min.	8. Date of B	irth ey, Year)	9. Birth	nplaca (State or Foreign untry)
,	Director		214-09-2765	UM ZQT	84	Yrs.				Dec. 2			land
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wo or Lov	nation						40d Inside Obstants
	the Marylan 28a-1 show	2			100. Oky, 10	WIT OF LO	Adilon						10d. Inside City Limits
	289-f	Sct	Maryland Washing	ton	W	illi	amsport						1 Yes 2 No
	F 22	ä	10e. Street and Number				10f. Zip Code)			10g. Citizen o	What Cou	untry?
	238	Ta l	16505 Virginia Av	enue			21	795			U.S	.A.	
	Herne Merre	Funeral Director	11. Marital Stetus	12. Was Decede Armed Forca	s?	13. V	Vas Decedent o Yas, specify Co	f Hispanic Or	igin? (Sp	ecify Yas or N Rican, etc.)	o- 14. Ri	ace - Amar ack, White	rican Indian,
20	72 hours after deeth with the Maryland naturel; or items 23s or 28s-f show Steel Examiner must be notified at		1 Nevar Married 2 Married	1 ☐ Yas 2 ☐	No		☐ Yes 2☑N				Spec	14	
21215-0020	rrsf',	d by	3 ☑ Widowad 4 ☐ Divorced	Year or Date	s:		Λ				Open	"y. Whi	te
5		Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	166	a. Deced (Give I	ent's Usuai Occ kind of work dor OO NOT use reti	upation ne during mos	at of work	ing	16b. Kind of	Business/I	ndustry
12	within ene. than	d E	Elementary/Secondary (0-12)	College (1-4d	or 5+)								
		ပိ	12	0		S	ecretar	-		The second second	Railr		
S S	be filed d other event,	Be	17. Fethar's Name (First, Middla, Last)					18. Mothe	ers Nam	e (First, Middli	a, Malden Sume	me)	
Z	should be filed and Mental Hygi merked other metic event,	2	Harry B. Martin					Rut	h E.	Barns			
Maryland	2 0 0		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailin	g Address (Stre	et end Numb	er or Run	al Route Num	ber, City or Tow	n, Stete, Zi	ip Code)
	f Heelth f Heelth ftem 27 other tr		Richard D. Schnur	r - Son			Oak Tr	ee Lan	e W	lilliam	sport,	Md. 2	1795
ore	00-		20a. Method of Disposition 1 □ Burlal 2 □ Cremation 3 □	Domousi from Sta	comet	of Dispos e <i>ry, crem</i>	sition (Nema of setory or other p	/eca)		Date	20c. Location	- City or T	Town, Stata
E			4 □ Donation 5 □ Other (Specific		11.1	Have	en Ceme	terv	1-	23-98	Hagers	town.	Maryland
Baltimore,	permit. Pe Departmen Important: any Injury		21. Signature of Funerel Service Licer	see/)			Name and Add		da e		Funeral		
m	80 = 50		James T.	Lower		4	15 E. W:	ilson i			erstown		21740
-			23a. Part1. Enter the diseasa, or com shock, or heart failure. List only	plications that caus	ed the death. Do					0			Approximate
ы	Physician		snock, or near failure. List only	one cause on each	1/1	-1		-				i	Interval Between Onset and Death
	/Medical		Immediate Cause (Final		Hours	Do	1/1	Fall	1140				7-211145
	Examiner		disease or condition resulting in death)	е	Care	C	EVAL uence of): VASC	1 710	24/1				CSWA
		Je.			A A Ch	consequ	dence on:		2 5			1	3-41.45
	uted	Examiner	Sequentially list conditions	b. ()	Due to (or as a			uai	57			1	3 / WKJ
ć	exectin en	Exa	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	V	Due 10 (01 as a	CONSOQU	261106 017.					1	
68760,	icete be executed physician end s the buriel-transit	cal	that initiated events	C	Due to (or as a	concodi	unna of):					-	
68	certificate be executed iding physician and ise es the buriel-transit	ed	resulting in deeth) Lest		Due to (or as a	consequ	ierica oi).					Į Į	
X	nding use	an/Medical		d									
m	the ettending		Post it Other planificant conditions -		han and an analysis			100000000000		001 01		1	
0	that the deat ed by the ett deteched for	Physici	Part II. Other eignificant conditions of	onthouting to death	//	in the un	denying cause	given in Part i	l.				to the cause of death?
0	signed to	by P	MASSIUGIUCH	ronany	Homa	na1.	MEG	- WIT	7/	1	Yes 2 TNo	3 Pr	obably 4 Unknown
rds	requires that the	Q D	1		+		4			24a. Wa	s en eutopsy	24b. V	Vere eutopsy findings
00	_ 00	ete	HUTE CESTIO	ATTHE	1 tAIC	unc	7. 11	+ Ram	BO-	perl	ormed?	a	vailable prior to
Re	The lew ete hes b pege 2 s	Completed	(1).	Dun	3 -01	A							f deeth?
a	icete		CY (OPENIA	1/14	say IV	Idu	yes!			10	Yes 2⊞No	1	☐ Yes 2☐ No
N N	Physician: The rather certificate rall director, peg	Be	25. Was case referred to medical examiner?	Hospital:			10	Mhor:		h (Check only			
of	this aldi	To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 L=Tinpa			3LI DUA	4 U N			idenca 6 🗆 O		rify)
2	ding F h. After funer	io	1 ☐Natural 5 ☐ Pending	28a. Date of Ir (Month, L	Dey Yeer)	Time of Injury	28c. In			280. Describe	how injury occi	14LOQ	
Sic	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be					Yes 2					
Division of Vital Records,	or Al	Certification:	4 ☐ Homicide determined	28e. Place of building,	injury - At home, f etc. <i>(Specify)</i>	arm, stre	et, factory, offic	a		281. Location City or To	(Street and Nun wn, Stete)	iber of Rui	ral Floute Number,
	urs eral [2											
	Hospital 24 hours Funeral tely filled	edicai	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam	uner: On the basis	of exemination a	e, death nd/or inv	occurred at the estigation, in my	time, date en	id placa, ith occurr	and due to the	cause(s) and r	nanner as	stated. to the cause(s)
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director,	Med	11mul	and mannar	stated.								
	To To		29b. Signatury	+1	7		29c. Lice	nse number			29d. Date sign	ed (Month	, Day, Year)
			Mulm	tour	14 Wa	m		1) 170	16)	[[]	20/9	8
	150		30. Name and address of person you	completed cause of	death (Item 23a)	(Type, F	rint)		/	1	1th		. 1.1
	D. Wall		STEPHEN E.M	ETZNEI	1, MD	/	4/ NO1	17Hon	N /7	WE.	110-160	21/71	ear, los
	Sta		31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	119	2						
	Registr	ar	JAN & I	1998	JUNE DAVID	100/-/	unated						



Stam baugh, Tracey

		State of Ma	aryland / Dep <i>Ce</i>	artment o <i>rtificate d</i>			giene 8	02542
Physician /Medical	Decedent's Neme (First, Middle Total	. _{Last)} Cracey Robi	in stame	AUGH		2. Dete of De Month	Day	Yee 3. Time of Death
Examiner	4e. Fecility Name (If not institution, Washington Cour.				4b. City, Town, Hager:	or Location of Deet	Wool	ington
Funeral Director	5. Sociel Security Number 215-78-3220 Usual Residence of Decedent	6. Sex 7. Ag 1 ☐ M 2 ☑ F	e (In yrs. last birthday 27 Yrs.	Months De		8. Dete of Bir (Month, De January	th by, Year) 7 9,1971	Birthplece (Stete or Foreign Country) Maryalnd
or 28a-f show	10a. State 10b. County Maryland Washin	gton	10c. City, Town or L Hagerst					10d. Inside City Limits XXYes 2□No
23a or 2 unit be na rai Dire	10e. Street end Number 123 Buena Vista	Avenue		10f. Zip Cod 217			10g. Citizen of V	
natural, or items 23s or 28s-f show or at Examinat the northed at eted by Funeral Director	11. Marital Status 1. Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces? ad 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U,S. 13.	Wes Decedent If Yes, specify (1 ☐ Yes 2 ☑		' (Specify Yes or No Jerto Rican, etc.)		e - American Indien, ck, White, etc. v: White
	15. Decedent' (Specify only highes: Elementery/Secondary (0-12) 0-12	s Education grade completed) College (1-4or 5	(Give	dent's Usuel Oc kind of work do DO NOT use re	ccupetion one during most of tired)	_		usiness/industry
d Mental Hyg marked othe matic event, To Be C	17. Fether's Name (First, Middle, L Marshal 19a. Informent's Neme/Relationsh	1 Vernon Sta		ine Address (Ct		Name (First, Middle Ruth And Route Numb	rene Nea	1
Department of Health and Mental Hygiena. Important: If item 27 is marked other than any injury or other traumatic event, the Mace. To Be Compl	Terry Baker/ si 20a. Method of Disposition 1□ Buriel 2 ☼Cremation	ster	Post 20b. Plece of Disponentery, cre	Office osition (Neme or metory or other	Box 530,	Clayton,	Georgi 20c. Location	a 30525 City or Town, State
Department important: any injury page.	4 Donetion 5 Other (Sp 21. Signature Funerel Service L	ecify)		2. Name end Ad	dress of Fecility	Minnich !	Funeral	ille, Georgia Home 1, Maryland 217
attending physicien end to use as the burial-transit and clan/Medical Examiner	Immediate Ceuse (Finel diseese or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that infilted events resulting in deeth) Lest	b. In-	Due to (or es e conse Due to (or es e conse Due to (or es e conse	quence of):	Henry Per	tensi	e ge	12 hours
ed by the datached	Pert II. Other eignificant condition	s contributing to deeth bu	ut not resulting in the u	inderlying ceuse	given In Pert I.		tobacco uee co Yes 2 No	ntribute to the cause of deeth? 3 Probably 4 Unknown
2 should			-4			24e. Wes	en eutopsy ormed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
after death. Director: After this cartification by the funeral director ertification: To Be	25. Was cese referred to medicel exeminer? 1	ation of be	ry Year) 28b. Time of Injury	of 28c. I	Other: 4 Nursin njury et Work? 1 Yes 2 No		one) dence 6 □Oth how injury occur	
n 24 hou he Funer pletely fil edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the best of xaminer: On the basis of end menner sta	examination end/or in	h occurred et the vestigetion, in m	e time, dete end pl ny opinion, deeth o	ece, end due to the ccurred et the time,	ceuse(s) end me dete end place,	enner es steted. end due to the ceuse(s)
To the company of the	29b. Signature and title of certifier 30. Name end eddress of person w	ho completed ceuşe of de	aday	l ani	ense number 4593	36	29d. Date/signe	98
	VA ITALLIE GILL GULLESS OF DOISON W	no completed ceuse of de	00111 (110111 230 V(1700.	- TITIL I				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

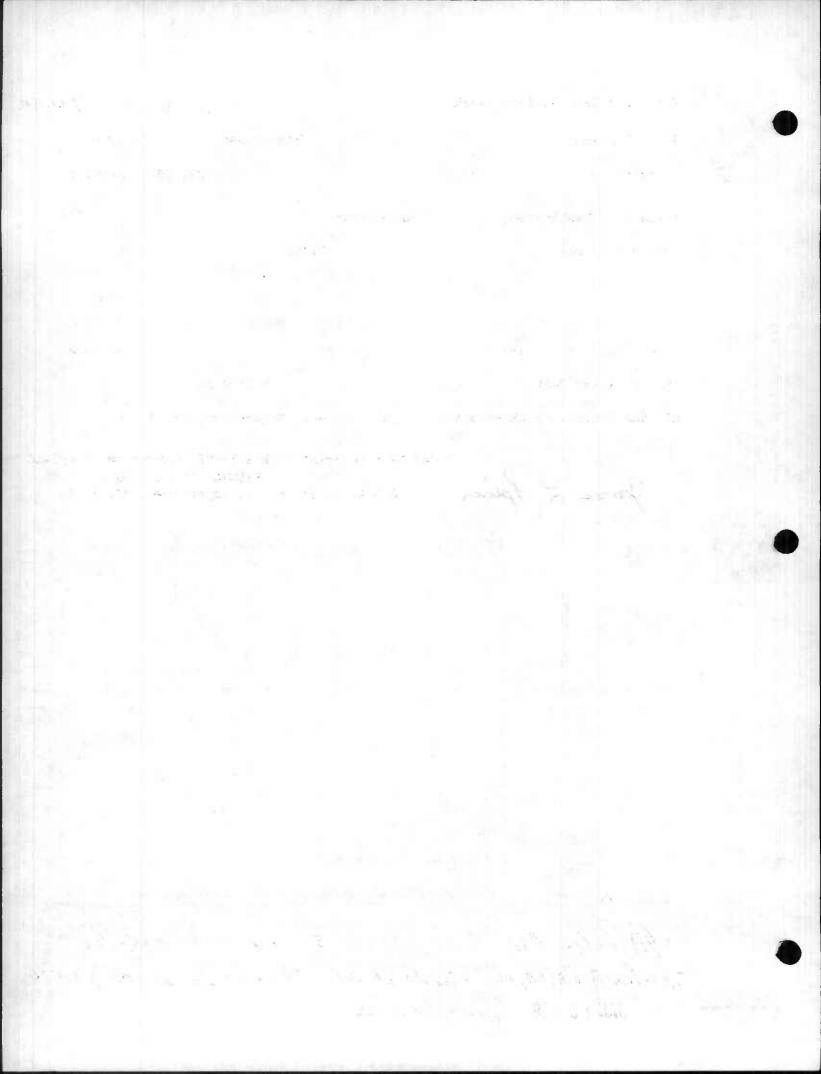


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month **Physician** Mildred Arlene Schlotterbeck 8:00 A.M. January 14, 1998 /Medical 4e. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 94 Park Avenue Hagerstown Washington Hours Min. 8. Dete of Birth (Month, Day, Yeer) 5. Sociei Security Number If Undar 1 Yaar 7. Age (In vrs. lest birthday) Birthpleca (Stata or Foreign Country) **Funeral** 1 □ M 2 K F Months Days 81 Yrs. Director 220-34-0358 June 22, 1916 Maryland Usual Rasidence of Decedent the Maryland 10a. State ral', or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 94 Park Avenue 21740 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indien Bleck, White, etc. filed within 72 hours efter 1 ☐ Yes 2 🕱 No If Yes, Give 1 ☐ Never Married 2 ★ Married "natural", or 21215-0020 1 ☐ Yes 2 X No Spacify: white þ If Yes, Give Yaar or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Dacadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collaga (1-4or 5+) unknown Elementery/Secondary (0-12) unknown homemaker her own home 7 is marked other traumatic event, altimore, Maryland 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be nant of Heelth and Mentel Harry Victor Smith Ruth Souders 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda) t: If item 27 la William Schlotterbeck - husband 94 Park Ave., Hagerstown, Md. 21740 20b. Place of Disposition (Nema of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cremetion 3 Removel from Stata permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial Park 1-17-98 Hagerstown, Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Fecility MINNICH FUNERAL HOME ocer 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1 Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. Physician Immediete Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner The law requires that the deeth certificate be executed for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in deeth) Last Box 68760. physicien Physician/Medical nctive bulmonary knew P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Disorder 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 8 24b. Were autopsy findings available prior to completion of causa of deeth? Completed 24a. Wes en autopsy certificate has 1□ Yes 20 No 1 ☐ Yes 2 No of Vital Physician: Be 25. Wes case referred to medical examinar? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this sa for Attending Physics after death.

In Director: After this ed in by the funeral d 27. Menner of Deeth 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Division 1 Natural 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28a. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stata) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completaly filled it 29a. Cartitier 1 Certifying Phyeician: To the bast of my knowledge, daath occurred et the tima, data end plece, end dua to tha cause(s) end mennar as stated.
2 Medical Examiner: On tha basis of examinetion and/or investigetion, in my opinion, deeth occurred at tha tima, date end place, and dua to the cause(s) end menner stated. Medical (Check only one) 29b. Signeture and title of certifier 29¢, License number 29d. Date signed (Month, Dey, Year) ASHA, MD 376 1912 57. HAGERS Town MD 21740 ASHA

32. Registrar's Signature

State Registrar 31. Deta filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2544

		Certificate of Death	Reg. No.	02044
Physician	Decedent's Name (First, Middle, Last)		2. Data of Death Month Day	3. Time of Death
/Medical		Stull Sr.	Jan 6,1998	10:55 am
Examiner	4e. Fecility Nama (If not institution, give street and number) Frederick Memorial Hospital		rick Fr	rederick
uneral irector	5. Sociel Security Number 215-36-6876 6. Sex 7. Age (In yrs. last bi	Yrs. Hunder 1 Year If Under 24 Hrs. Hours Min.	8. Dete of Birth Month, Pex. Year July 10, 1904	9. Birthplece (State or Foreign Maryland
M 18	10e. Stete 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
tor.	Md. Frederick Thu	ırmont		1 ☐ Yes 2 CNo
ai Direc	10e. Street and Number 7913 Lewistown Road	10f. Zip Coda 21788	10g. Citizen of V	What Country?
by Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Naver Married	13. Was Decedent of Hispenic Origin? (Spif Yes, specify Cuban, Mexican, Pueric	pecify Yes or No- D Rican, etc.) 14. Reco	e - Amarican Indian, ck, Whita, atc. y: White
eted	15. Decedent's Education (Specify only highest grade completed)	n. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)	18b. Kind of Bu	usiness/industry
Completed	Elementary/Secondary (0-12) College (1-40r 5+)	iiie. DO NOT use retired) Farming		airy
S. S.	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Sumam	
or other traumatic event, tra Medical	Newton S. Stull		rothy Miller	,
To		b. Mailing Address (Street and Number or Rui	•	Stata, Zip Code)
Jer um		7908 Woodville Rd.		
	n one of	of Disposition (Name of cry, crematory or other place) naven Mem. Garden:		city or Town, Stata derick, Md.
any injury	Pobert W. Keeney #M005	Keeney & Basion 22 106 E. Church	rd P.A. Funer	ral Home
cian lical iner	23a. Part1. Enter the diseesa, or complications that causad tha death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Finel diseese or condition resulting in death) Due to (of as e	consequence of):		Approximate triterval Between Onset and Death
i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.	consequence of):		
for use es the burial-transit		consequence of):		
Ciar	Part II Other significant conditions contribution to death but not condition	in the underlying serves about in Dart I	22h Did toheana use na	ntribute to the cause of death?
d by Physician/N	Part II. Other significent conditions contributing to death but nonvesulting	n the underlying cause given in Part I.		3 ☐ Probably 4 ☐ Unknown
2 shoul	aring retor	twi	24e. Wes an eutopsy performed?	24b. Were autopsy findings availebla prior to completion of causa of deeth?
Com			1 ☐ Yes 2 ☐KNo	1 ☐ Yes 2 ☐ No
director,	25. Wes casa referred to medical examiner?		th (Check only one)	
Jo die	1 ☐ Yes 2 ☐No Hospital: 1 ☐ Inpatient 2 ☐ ER/O		ome 5 Residence 6 Oth	
completely filled in by the funeral di Medical Certification: To	1 Natural 5 Pending (Month, Day Year) Investigation	Time of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurr	
Certif	4 Homicide determined 28e. Piece of injury - At nome, to building, etc. (Specify)		28f. Location (Street and Numb City or Town, State)	
pietely fii edicai	29a. Certifier (Check only one) Certifying Phyalcten: To the best of my knowledg 2 ☐ Medicat Examiner: On the basis of examination end manner steted.			
w Com	29b. Signature and title of certifier	29c. License number	a	ry 6, 1998
	30. Name and address of persor who completed cause of death (Item 23e) Dr. William F. Harper MD, 1	(Type, Print) 00 S. Center St.,	Thurmont, Me	d. 21788
State	31. Dete filed (Month, Day, Year) 32. Registrar's Signature	1 70 7		

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A MANAGE AND THE STREET

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Jan. 14, 1998 **Physician** Yaar Ina Daisy Spade 12:59 AM /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3387 Red Oak Ct. Middletown Frederick 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth Month Day, Year) Mar. 15, 1911 Birthplace (Stata or Foraign Country)
 Pa 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Days 1 M 2 KF 86 Yrs. 214-32-4017 Director Usual Residence of Decadent tha Maryland 10a Stata 10h County 10c. City, Town or Location 10d. fnsida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercition mant be notified at Frederick Middletown Director 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 72 hours after death with 3387 Red Oak Ct. 21769 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ②No if Yas, Giva Yaar or Datas: 11. Marital Status 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amaricen Indian, Black, Whita, atc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: by Specify: White 3 Widowed 4 □ Divorcad Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grada complated) filed within I Hygiana. permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiana. Important if flem 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) Collega (1-4or 5+) homemaker 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Sumeme) Be J. Albert Clark Mary Gordon 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zlp Coda) Beulah S. Bidle (Daughter) 3387 Red Oak Ct., Middletown, Md. 21769 20b. Place of Disposition (Nama of comatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 X Burlal 2 Cramation 3 Ramoval from Stata Little Rose Hill Cemetery Clear Spring, Mil. 4 ☐ Donation | 5 ☐ Other (Specify) 1/16 21. Signature of Funeral Service Lig 22. Name and Address of Facility
Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. Approximata 23a. Part 1. Enter the disease, or complications/that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immadiata Causa (Final disaasa or condition rasulting in death) /Medicai 4 01 Examiner Dua to (or as a consequence of); 10100 00-00000 Saquentially list conditions, if any, laeding to immadiata cause. Enter Underlying Causa (Disease or Injury that initiated avents rasulting in death) Last and Dua to (or as a consequence of): that the death certificate be axed attending physician for use as the buria Box 68760 Luows Un Physician/Medical Dua to (or as a consequence of): P.O. ed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed to Division of Vital Records, à 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? Completed peen : has page 2 certificate 1 Yas 2 No 1 Yas 2 No To the Hospital or Attanding Physician: within 24 hours aftar death.

To the Funeral Director: After this certifical completally filled in by the funeral director, 25. Was cesa rafarred to medicel axeminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Certification: To 28e. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding invastigation 1 Natural 1 Yes 2 No 2 Accidant 6 Could not be detarmined 3 ☐ Sulcida 28a. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifler Medicai (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Data signad (Month, Day, Yaar) D146 26 30. Nama and addrass of parson who complated causa of daath (Itam 23a) (Type, Print) Mause 4 MA W 5 20001 56 F-2010-10 1912 2130 32. Projector Signatura 31. Data filed (Month, Day, Yaar) 1998 State Registrar

State of Maryland / Department of Health and Mental Hygiene

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tant diny	□ Donation 5 □ Other (Specify	/)	Resthav	ven Mem	oria1	Garder	s 1-16-9	8 Frede	erick, Mar	y1a
21. Si	gnature of Funeral Service Licen	isee		22. Name	and Addre	ss of Fecility	Stuaffe	r Funera	1 Home	
2 = 4 0				1621	Oposs	umtown	Pike. Fr	ederick.	Maryland	
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29b. S	ignature and title of certifier	0,5	/	2	9c. Licens	e number	9	29d. Dete signe	d (Month, Day, Year) 3 98	1
30. Na	me and address of person when the line of	emploted cause of dea	th (Item 23a) (Cent	rer St	The	urmond	3/98 , Md. 2	-1-

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ledic	al	Irene	Rebecca	SCHU	ILTZ	4h Cihi Tour	January		-	11:25 P.1
ımin	er	4a. Fecility Name (If not institution, give College View Nu		ter			or Location of Deetlerick	4c. County		erick
erai	-	5. Sociel Security Number 6. Se		(In yrs. last birthda	y) If Under 1 Year	If Under 24 H		th		ce (State or Foreign
tor .		214–10–2733	□ M 2 XF 85	5 Yrs.	Months Days	Hours Mi	in. (Month, Da March 2	y, Year) 28, 1912	Pe	ennsylvani
		Usual Residence of Decedent 10e. State 10b. County	1	10c. City, Town or	Location				100	d. Inside City Limits
	tor	Maryland Frede			Frede	rick			100	1 ☐ Yes 2♥ No
	I Director	10e. Street and Number 8830-A Yellow St	orings Road	i	10f. Zip Code	21702		10g. Citizen of W	hat Country U.S.	
	by Funeral	11. Maritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		3. Wes Decedent of I if Yes, specify Cub 1 ☐ Yes 2 🙀 No	Hispenic Origin? en, Mexicen, Pur Specify:	(Specify Yes or No erto Ricen, etc.)	- 14. Race Bleck Specify:	- Americer k, White, etc	
		15. Decedent's Edu (Specify only highest grad	ucation	16a. Dec	cedent's Usual Occup	petion during most of w	working	16b. Kind of Bu	siness/Indu	stry
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	To Be	Edward Dellet				1000	Rebecca M		-/	
		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Ma	iling Address (Street				State, Zip C	Code)
		Albert W. Schultz/	/Husband		-A Yellow	Spring				
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetlon 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dis cemetery, co ROCKY Sp	position (Name of rematory or other pla orings Cem	etery J	an 14. 19	20c. Location - 6	City or Tow derick	n, State ₹ - MD
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		Part I. Enter the disease, or compi shock, or heart feilure. List only o	lications that caused th	ne death. Do not e			Street liac or respiretory a		A	Approximete
an cal ner		Immediate Cause (Final disease or condition resulting in death)	a. Alsk	heemer		esse				ntervel Between Onset end Deeth
	-		Du	ue to (or as e cons	equence of):					
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DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death THELMA BELLE STONE January 6, 1998 5:45 A.M. 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 7738 Kemp Lane Frederick Frederick 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 1 M 2XX Months Deys Hours Yrs. 236-28-5703 March 24, 1918 Maryland Usuat Residence of Deceden 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Seneca Tippin 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 703 Spayth Street 44883 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 Never Merried 2 Married 1 Yes 2√No Specify: 3 Widowed 4 □ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) +4 School Teacher Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Earl A. Warnick Elsie Mae Umstot 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7738 Kemp Lane Mary Louise Stone, daughter Frederick, Maryland 21702 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) Greenlawn Cemetery 1/10/98 Tiffin, Ohio 22. Name end Address of Fecility Stauffer Funeral Homes, P.A. 21. Signeture of Funerat Service Liconson 1621 Opossumtown Pike Frederick. MD 21702 Do not enter the mode of dying, such es cardiac or respiratory errest, Approximate Intervel Between Onset end Death Immediate Ceuse (Final pieural 1 I week malignant disease or condition resulting in deeth) malicnant 3 years metastatic Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacce-use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy completion of ceuse of deeth? Yes 2□ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to-medical Specify)

Physician /Medical Examiner

cartificate be axecuted

Box 68760.

P.O. 1

Records.

Division of Vital

permit. Pages 1 and 2 should be filed with Department of Health and Mantal Hygiens important: if flem 27 is marked other that any Injury or other treumatic

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at

72 hours after

Baltimore, Maryland 21215-0020

Director

Funerai

by

Completed

Be

end attending physician tha 80 this certificata To the Hospital or Attending Physician: within 24 hours after daath.

To the Funeral Director: After this certifica completely filled in by tha funeral director, to

Examiner Physician/Medical þ Completed Be 2 Certification:

29a. Certifie (Check only one)

Part II. Other eignificant conditions contributing to death but not resulting to the underlying cause given in Pert I.

. TVOS CASO ISTOTION CATIONICAL				26. Place of De	etn (Check only one)
exeminer? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	ER/Outpetient	3□ DOA	Other: 4 Nursing H	Home 5 Residence 6 Other (S
7. Manner Deeth 1 Neturel 5 Pending	28e. Date of Injury (Month, Dey Year	28b. Time of Injury		Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how Injury occurred

3 Sutcide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier

29c. License number D43083

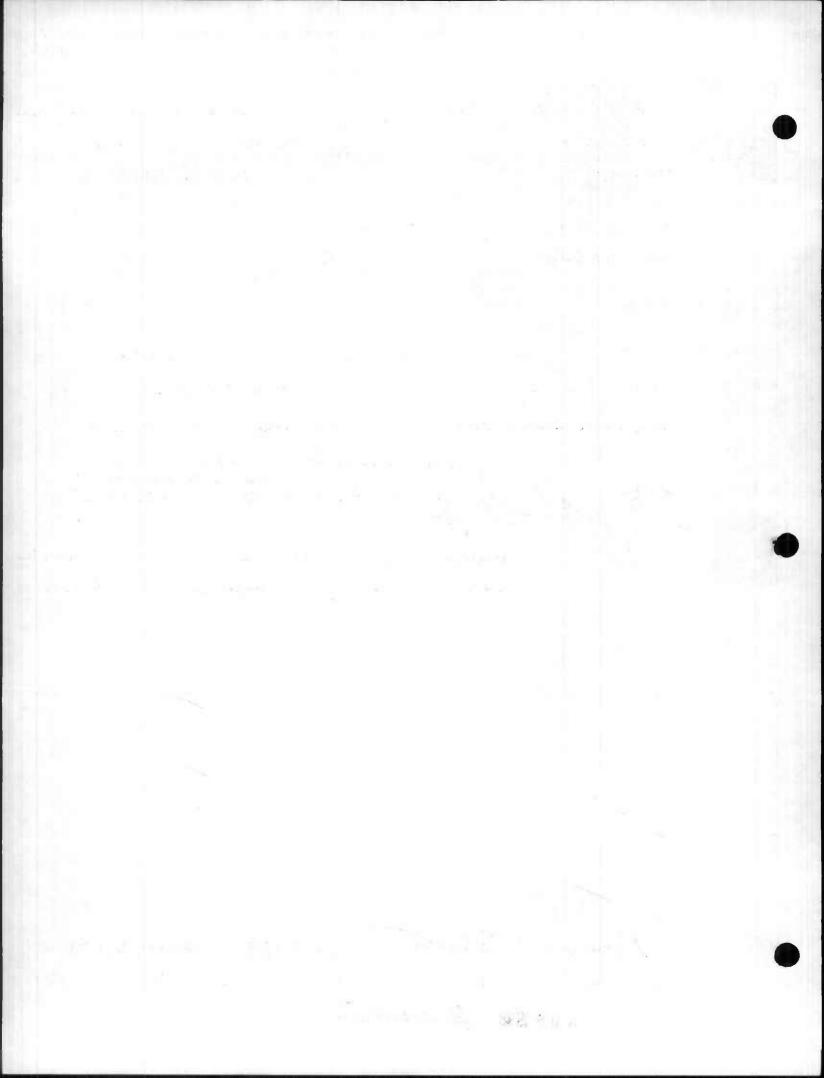
29d. Date signed (Month, Dey, Year) JANUARY 6, 1998

30. Name end eddress of person who completed cause of deeth (ttem 23e) (Type, Print)

9707 Med. Center Dr + 300 R'ville 20850 George 20105 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signeture



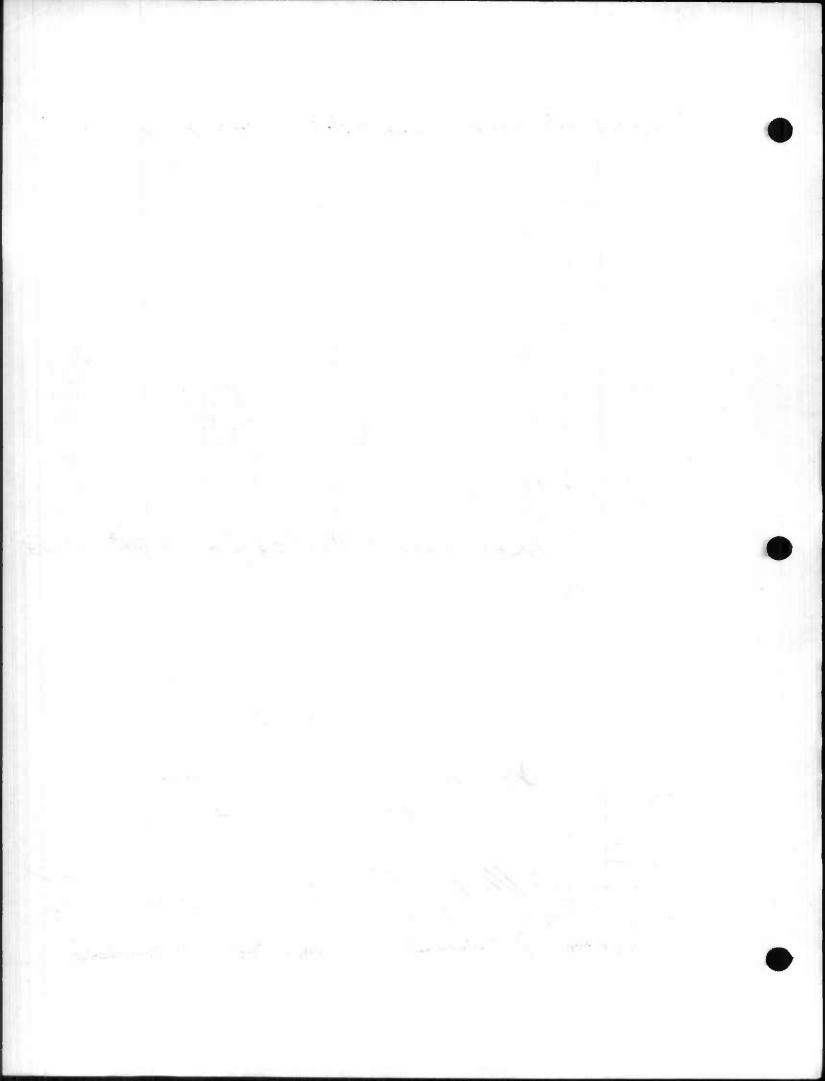
112549 98

FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, La 2. DATE OF DEATH 3. TIME OF DEATH 7:20 EORGE AN 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 6. AGE (In yrs, lest birthday) BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 F 281-16-2409 YRS. 73 May 19, 1924 Ohio Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 9623 Harvest Knolls Way Gaithersburg Montgomery RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Gaithersburg t TYES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 9623 Harvest Knolls Way 20882 burial-transit United States Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 X Merried If yes, specify Cuban, Mexican, Puerto Rican, stc.) 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced detached for use as the White W.WII ETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondery (0-12) College (1-4 or 5+) 5+ COMPL Civil Engineer Private Consultant once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Ħ Scott Slaughter Dorothy Dodds BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20882 2 9623 Harvest Knolls Way, Gaithersburg, Maryland Jane Neill Slaughter/Wife pe 20a. METHOD OF DISPOSITION
1 ☐ Buriel 2 🏋 Cremation 3 ☐ Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, Metropolitan Crematorium 1/7/98 Alexandria, Virginia 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY Olin L. Molesworth P. A. Funeral Home hours after death. filled in by the fi 26401 Ridge Road, Damascus, Maryland 20872 medical 23. PART t. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, shock, or heart failure. List only one cause on each line. Approximata intervel Between Onset and Death IMMEDIATE CAUSE (Finel cremation, the disease or condition resulting in death) and completely fill burial, cremation SANGUATION DUE TO (OR AS A CONSEQUENCE OF): event, executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING signed by the attending physician Health and Mental Hygiene prior to OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Injury. PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 7 shows a 1 YES 2 NO t. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: s certificate has be th the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) Item HOSPITAL **EXAMINER?** OTHER: YES 2 NO ☐ Inpstient 2 ☐ ER/Outpatient 4 Nursing Home 8 Other (Specify) 0 28b. TIME OF 27. MANNER OF DEATH DATE OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, this c 5 Pending 1 Natural 1 YES DIRECTOR: After the hours after death BY 2 Accident 3 Suicide atrest 60 a Could not be COMPLETED 28 Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end piece, end due to the cause(e) and menner as stated. (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and piece 29c. LICENSE NUMBER BE 2 W00 \$1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MARYLAND 21215-0020 BALTIMORE,

BOX 6876 0 OF VITAL RECORDS, DIVISION



State of Maryland / Department of Health and Mental Hygiene A

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Dev **Physician** Month 11:00 AM Ancle Clay Tester Jan 14, 1998 /Medical 4e. Facility Nema (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner 3824 Copperville Way Temple Hills

If Under 1 Year | If Under 24 Hrs. 8. Deta Prince George's 5. Social Security Number 7. Aga (In yrs. lest birthdey) 8. Deta of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 XM 2 □ F Deys Hours 215-05-9909 86 Yrs. Director Nov. 20,1911 Virginia Usual Residence of Deceden deeth with the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Madical Exempler must be notilled at 1 Yes 2 No Director Maryland | Prince George's Temple Hills 10e. Street end Numbar 10f. Zip Code 10g. Citizan of What Country? U.S.A. 20748 3824 Copperville Way Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yas or No If Yas, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after of Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or then any injury or other traumatic event, the Madical Exercise. 1 ☐ Yas 2 █️No If Yas, Giva Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 📉No Specify: þ 3 Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usuel Occupation
(Giva kind of work done during most of working life. DO NOT use retired)

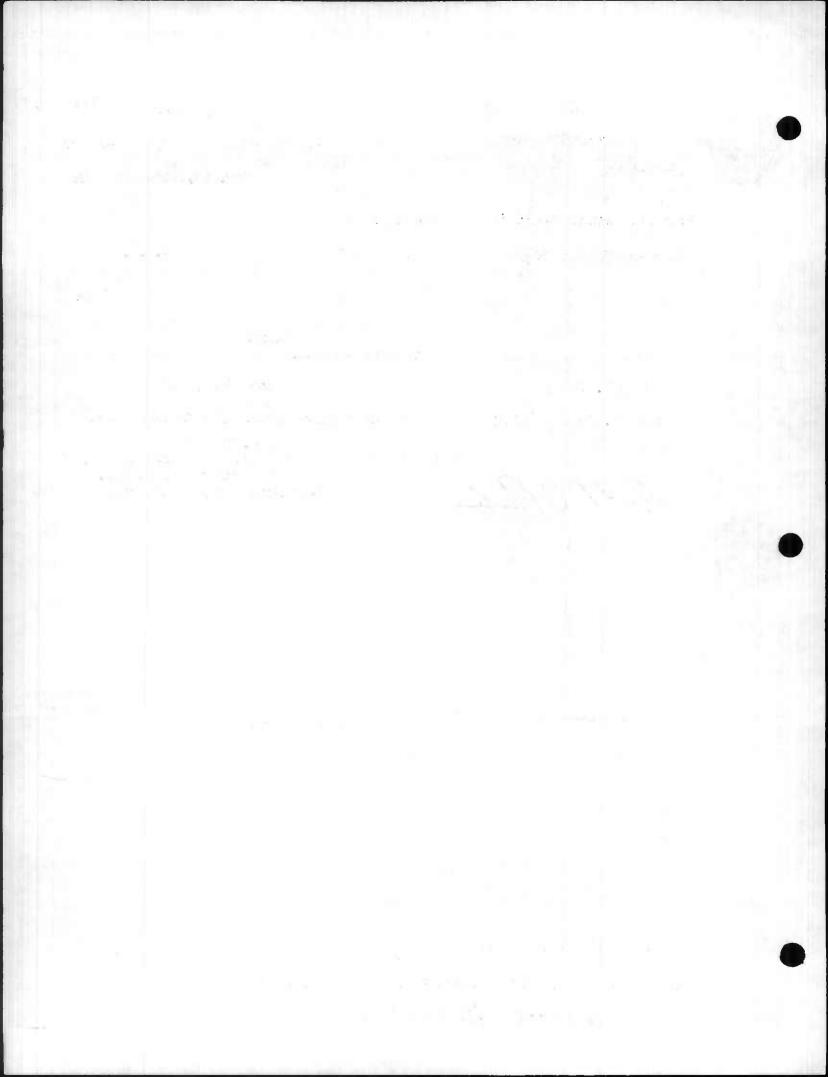
RETIRE 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A 12th General Contractor Self-Employed 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Ida (Unknown) John W. Tester 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ancle R. Tester 3807 Cedar Drive Silver Hill Maryland 20746 (Son) 20b. Plece of Disposition (Name of cematary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan Date 9. 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 1998 Silver Spring, MD 22. Name end Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximeta Intervel Between Onsat end Death **Physician** /Medical immediete Cause (Final diseasa or condition resulting in death) 2 days Examiner Due to (or es e consequence of). physicien end the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequença of): P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) ed by the attending p deteched for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detech 1 Yes 2 No 3 Probably 4 ₩nknown Records, þ 24b. Were eutopsy findings availabla prior to completion of cause of deeth? Completed 24a. Was en eutopsy parformad? 1 Yas 2 10 Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica 25. Wes case referred to medical exempler? 26. Piece of Deeth (Check only one) noup Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Ves 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Rome funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Certification: 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.

2 Medicat Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) and menner stated. 29a. Certifier Medical completely 29b. Signeture and title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Paul Wilson, M.D. 7501 Surratts Road #302, Clinton, Md 20735 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

Julia Structur Rawlatt

Registrar



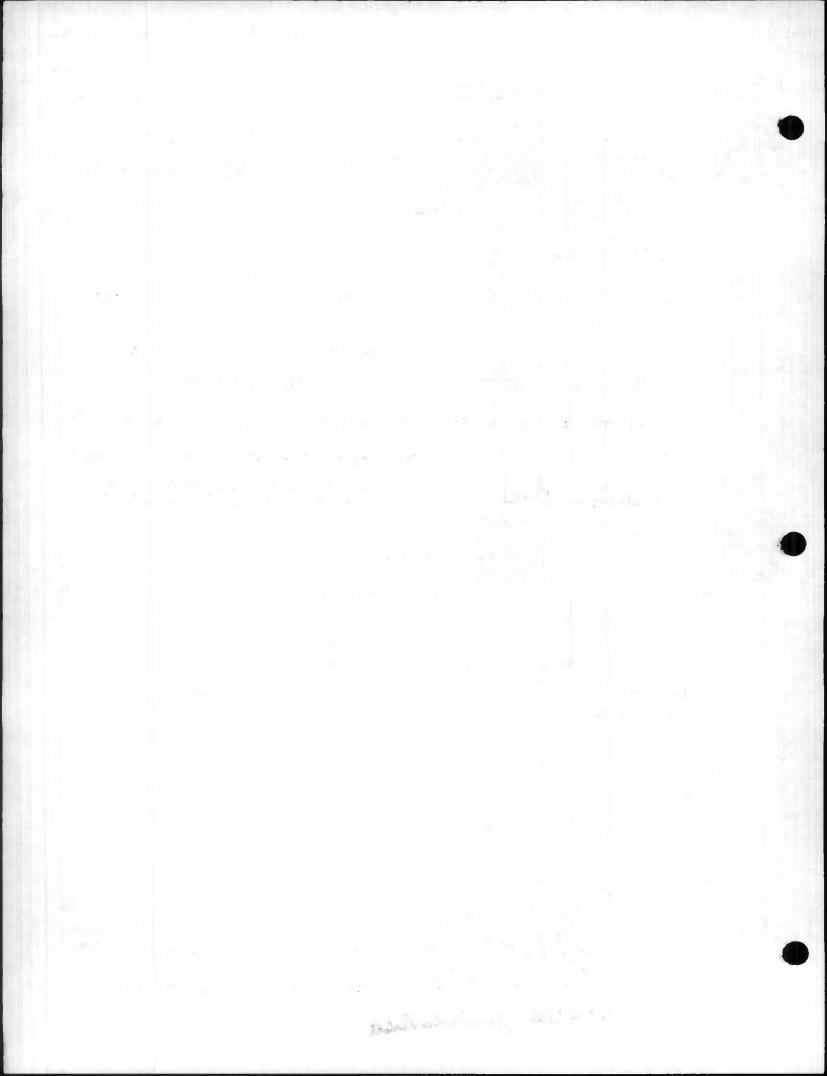
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Jahuary 14, 1998 12:55 AM Genevieve Selena TIMM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Dete of Birth (Month, Day Year Sept. 19, 1 9. Birthplece (Stete or Foreign **Funeral** Months Days Maryland 1□M 25 F 219-36-4051 78 Yrs. Director Usual Residence of Decedent with the Marylend 10e. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Frederick Frederick Director 1 ☐ Yes 2 XXVo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21701 6012 Quinn Road Funeral filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck. White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No White þ Specify: 3 Widowed 4 □ Divorced Completed Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Own Home permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: if item 27 is marked other th
any injury or other traumatic event, the Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WACHTER Ella Selena FOUT William Lewis 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 4104 Lynn Burke Road, Monrovia, Maryland 21770 Mrs. Margaret Brashear, Daughter Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Mount Olivet Cemetery, January 17,1998 Frederick, Maryland 21. Signeture of Funeral Service License ^{22. Name end Address of Facility}. Keeney and Basford P.A. Funeral Home 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 106 East Church St., Frederick, Md. 21701 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CARCINO MATOSIS Examiner Physician/Medical Examiner The law requiras that the death certificeta be axecuted burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest and Division of Vital Records, P.O. Box 68760 physician the Due to (or es e consequence of) 88 usa ò signed by the e Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA þ 24b. Were autopsy findings aveileble prior to completion of ceuse of death? 24a. Wes en eutopsy Completed has 20 No this certificate 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: diractor, 25. Wes case referred to medicel examiner? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Yeer) funerel 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred : Aftar ! 1 Neturel 5 Pending investigation To the Hospital or Attendin within 24 hours eftar death.

To the Funeral Director: At completaly filled in by the fu 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 ☐ Medical Exa iner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of cartifis 29c. License number 29d. Date signed (Month, Dey, Year) January 16, 1998 D 18063 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 801 Toll House Avenue, Frederick, Maryland 21701 Abdul Majeed 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Julia Davidson Park JAN 1 6 1998

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 8 0 2 5 5 2

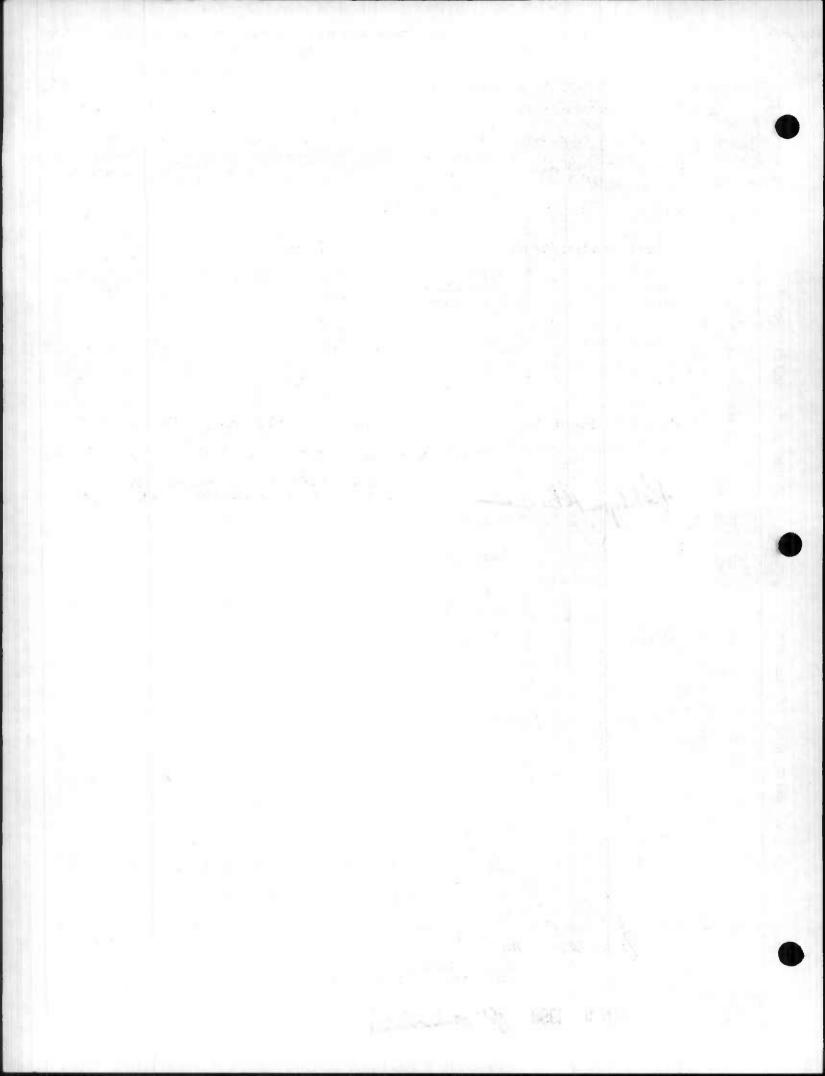
Robert Kenneth Tritt Sanuary 10, 1998 3:20 As Felin Name (fron instanction, per street and number) 2.3 Foxrock Drive 10, 290 20, 290 20, 20						Certificat	e of	Death		1	Reg. No.	0 6	.006	
Kopert Kenneth Tritt Sanuary 10, 1998 31/2	Division		1. Decedent's Name (First, Middle, La	ast)	119							V	3. Time of De	eath
Property As Feating Name of not institution, give street and number 23 Foxrock Drive 23 Foxrock Drive 25 Foxrock Drive 5. Social Security Number 6. Security Number			Robert Kenne	th Tritt							10, 19		3:20 p	p.m
Social Security Number C. Sax T. Age (to yrs. Nest berinday) Funder 1 Vair T. Vair T			4a. Facility Name (If not institution, given	ve street and number)				4b. City, To	wn, or Loc	cation of Death		of Death		
210-26-7063 XM 2]F 64 Yrs. Moroths Days Hours Min. (Mining Asy, Year) Pennsylvan Penns			23 Foxrock Dr	rive				Myer	svil	le	Fred	lerick	ζ	
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Total Control Total Contro			210 20 ,000	1 M 2 F	64 Yr	s. Months	Days	Hours	Min.	Aug. 14	, Year)	Penns	_{sylvania}	3
Elemantary/Secondary (0-12) Collaga (1-4or 5+) Certified Public Accountant Internal Revenue	and *-				10c. City. Town o	or Location						1	Od Incide City I	Limite
Elemantary/Secondary (0-12) Certified Public Accountant Internal Revenue 17. Father's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23. Foxforck Drive, Myersville, Maryland 21773 23. Foxforck Drive, Myersville, Maryland 21773 23. Foxforck Drive, Myersville, Maryland 21773 24. Donation of Driver (Specify) 25. Signature of Fubinal Special Disposition (Name of Comelleny, crematory or cheer place) 25. Signature of Fubinal Special Disposition (Name of Comelleny, crematory or cheer place) 25. Signature of Fubinal Special Disposition (Name of Comelleny, crematory or cheer place) 26. Description of The Place of Disposition (Name of Comelleny, crematory or cheer place) 26. Description of The Place of Disposition (Name of Comelleny, crematory or cheer place) 26. Description of The Place of Disposition (Name of Comelleny, crematory or cheer place) 26. Description of The Place of Disposition (Name of Comelleny, crematory or cheer place) 27. Signature of Fubinal Special Disposition (Name of Comelleny, crematory or cheer place) 28. Part Enter the Genera, of Comelleny, crematory or cheer place of Disposition (Name of Comelleny, crematory or cheer place) 28. Part Enter the Genera, of Comelleny, crematory or cheer place of Disposition (Name of Comelleny, crematory or cheer place) 28. Part Enter the Genera, of Comelleny, crematory or cheer place of Disposition (Name of Comelleny, crematory or cheer place) 28. Part Enter the Genera, of Comelleny, crematory or cheer place of Disposition (Name of Comelleny, crematory or cheer place) 28. Part Enter the Genera, of Comelleny, crematory or cheer place of Disposition (Name of Comelleny, crematory or cheer place) 28. Part Ent	Ba-f sho	ctor		.ck									1 N Yes 2[
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March minute is a series of 1 14 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, Last)	C	ertificate of	Death	2. Date of Deal	eg. No. 🤰 🔵	UZ	3. Time of Death
Physicia /Medic		Bernard	Frankli	in	TOBIN		January	7, 199	Veer	:40 pm
Examine	_	4a. Facility Name (If not institution, give Homewood Retireme	street and number)			4b. City, Town, or L Frederic		4c. County		
Funeral Director		100 10 1332	X 7. Age (li	n yrs. last birthda 78 Yrs.	y) If Under 1 Year Months Days		8. Date of Birth (Month, Dey Mar 15,	Year) 1919	9. Birthplac Country New	e (State or Foreig York
h the Maryland r 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederi		c. city, Town or Freder					10d.	Inside City Limit Y Yes 2 □ N
death with the Maryland	Funeral Director	10e. Street and Number 31 West Patrick S	treet		10f. Zip Code	21701	1	0g. Citizen ot \	What Country	?
urs efter af', or ite	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Decedent Eve Armed Forces? 1-2 Yes 2 No If Yes, Give Year or Dates:	1942– 1968	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		ecify Yes or No- Rican, etc.)		e - American ck, White, etc .: Whi	
within than .	Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)	cation le completed) College (1-4or 5+)	(Gin life	cedent's Usual Occup ve kind of work done DO NOT use retire	during most of work ad)	ing	16b. Kind of Bu		
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2 should and No.		19a. Informant's Name/Relationship (T)	(pe, Print)	19b. Ma	iling Address (Street	t and Number or Rui	al Route Number	City or Town,	State, Zip Co	ode)
ges 1 and it of Haalth If item 27 or other to		Michael B. Tobin/ 20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State	20b. Placa of Dis	1 Devon La position (Name of rematory or other pla n Nat I Co		Date	20c Location -	City or Town	State
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	ledical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	a to (or as a cons Atteless a to (or as a cons to (or as a cons	equenca of):	diseas			y	tean tean
v requires that the death cert been signed by the attanding should be detached for use i	Completed by Physician/M	Part II. Other algnificant conditions cor	d	ot resulting in the	underlying cause gi	ven in Part I.	23b. Dld to	bacco uee co	ntribute to th	e cause of dest
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To the Nexpital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this cardificate has completely filled in by the funeral director, page 2	Certification:	3 Sulcide 6 Could not be determined	28e. Placa of Injury - building, etc. (S	At home, tarm, s	street, factory, office		28f. Location (St City or Town	reet and Numb n, State)	er or Rural R	oute Number,
To the Hospital within 24 hours To the Funeral completely filled	edlcai	29a. Certifler (Check only one) 1 Certifying Physical Examination (Check only one)	sicien: To the best of moner: On the basis of exa and manner stated.	amination and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and ma ate and place,	inner as state and due to the	ed. e cause(s)
withir To th comp	Me	29b. Signeture and talle of certifier	m		29c. Licens D18	se number 3063		9d. Dete signe anuary		
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacadant's Name (First, Middla, Last) 2. Data of Death Month **Physician** Yaar HELEN WINIFRED VARRY 839 1998 /Medical 4a. Fecility Nama (If not institution, giva straat and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital HAGERSTOWN Washington If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Day, Yaar) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foraign Country) **Funeral** 1 M 2 XF Days 129-12-6585 Vrs Director 80 January 3, 1918 New York Usual Rasidence of Dacadant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ehow other traumatic event, the Medical Examiner mant be notified at 1 ☐ Yes 2 No Director Washington Williamsport 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? 0 10720 Timothy Drive or Items 23a 21795 USA Funeral 12. Wes Decedant Evar in U,S. Armad Forcas? 1 ☐ Yes Ž No If Yas, Giva Yaar or Dates: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) Race - American Indien, Bleck, Whita, atc. 1 Naver Married 2 Married 1 ☐ Yas 2 🛛 No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hours Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", any injury or other traumatic succession. White Completed 15. Decedent's Education (Spacify only highast grada completed) 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) Homemaker Personal Residence 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) James Cox Helen Reilly 2 19a. Informant's Name/Ralationship (Type, Print) Daughter 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Patricia Ellen Biancolli 428 Links View Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Data 1X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata St. Charles Cemetery Jan. 23 Long Island, New York 4 □ Donation 5 □ Othar (Specify) 22. Name and Address of Facility
Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 sa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, but only descause on each line. Approximeta Intarval Between Onset and Death Physician Severe Congetin heart failure Immediate Ceusa (Final disaasa or condition rasulting in daath) /Medical Examiner my ocardial infarction, Septal Examiner buriel-transit Sequentially list conditions, if eny, laading to Immediata ceusa. Enter Underlying Cause (Disease or injury thet Initiated evants rasulting in daath) Last end Cormary artery disease
Due to (or as a consequence of): ettending physician for use as the burie Physician/Medical gartic Stenosic Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown himers dementer þ 24b. Ware eutopsy findings evailabla prior to complation of ceusa of death? 24a. Wes en autopsy performed? Completed restencias certificate 1 Yas 2 No 1□Yes 2□No 25. Was cesa refarred to madicel axaminer?
1 ☐ Yas 2 ☐ In Be 26. Placa of Daath (Chack only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? Diractor: After 1 Natural or Attending 5 Pending Invastigation death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be daterminad 281. Location (Straat and Number or Rurel Routa Number, City or Town, State) 3 Suicida n 24 hours after do
ne Funeral Direct
bletely filled in by 28a. Plece of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar Medical (Check only one) To the I 29c. Licansa numbar 29d. Data signed (Month, Dey, Yeer)

STAFF PHYSICIAN

32. Registrar's Signatura

Julia Davidson

30. Nama and eddress of person who complated ceuse of death (Itam 23a) (Type, Print)

50882

11110 Medical Campus Rd. Hag

State Registrar

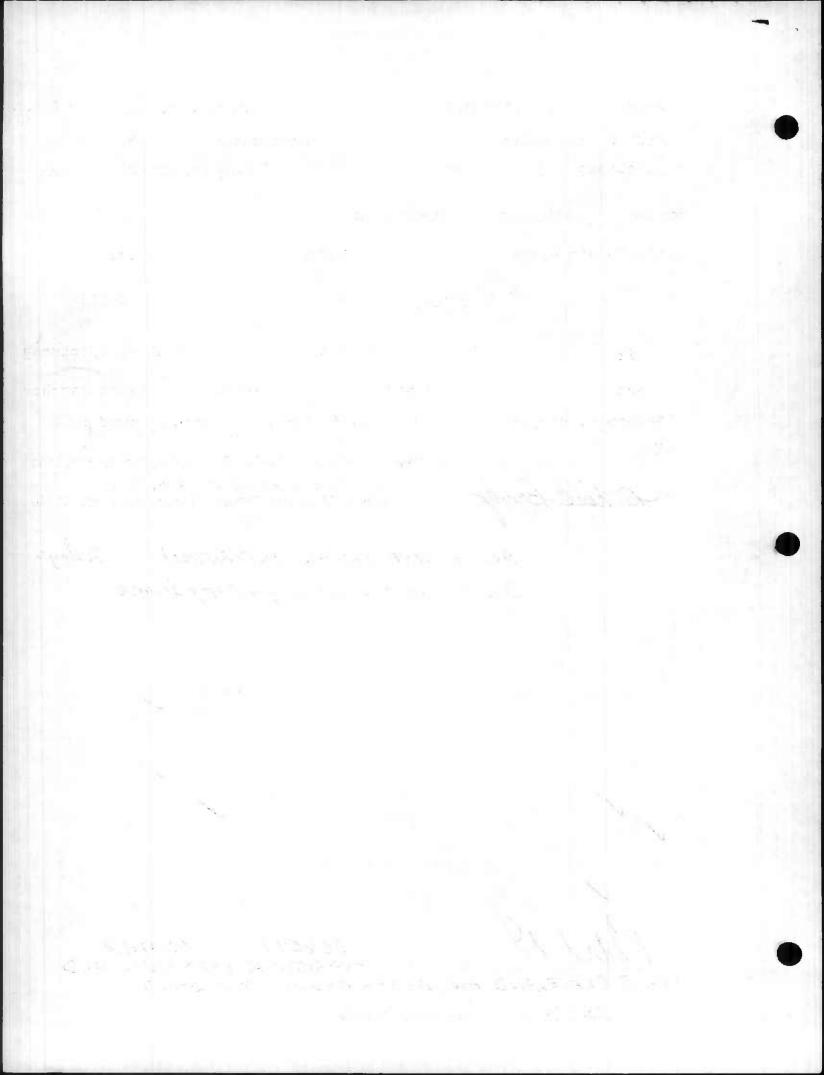
Division of Vital Records,

Baltimore, Maryland 21215-0020

Littly College

State of Maryland / Department of Health and Mental Hygiene 8

					Ocitii	icale o	Dealli		Reg.	No.			
Physic /Med		Decedant's Nama (First, Middla, La JAMES PAUL	WINGH				-	Jar	nuary 1	Day 15, 19	Yaar 98	3. Time of Deeth 12:30 A.	
Exami	ner	4a. Facility Nama (If not institution, giv 19826 Bennie)				vn, or Location erstov	100	4c. County	of Death hingt	on	
Funeral Director		723-18-2986	Sex 7. A 1 M 2 □ F	ge (In yrs. lest b		Under 1 Year onths Day		Min. 8. Da	ta of Birth Jonth, Day, Ye Ly 16,	1928	9. Birthplac Country Penns	e (State or Foreign /lvania	
Maryland I-f show	tor	Usual Rasidance of Dacedant 10a. Stata 10b. County Maryland Washi	ington	10c. City, To	wn or Locati						10d	. Insida City Limits 1 ☐ Yes 2 🕅 No	
r 28a	rec	10e. Street and Numbar				10f. Zip Code	1		10g. Citizan of What Country?				
h with	a D	19826 Bennie Drive 21742								U.S	.S.A.		
be filed within 72 hours after death with the Maryland stal Hyglene. Id other than "neturel", or Items 23e or 28s-f show event, the Medical Exeminer must be notified as	by Funeral Director	11. Marital Status 1 Navar Marriad	12. Wes Dacedant Ever in U,S. Armed Forcas? 1 TYes 2 No H Yas, Giva Yaar or Datas: Conflict.				f Hispanic Orig uban, Mexican, o Spacify:	in? (Specify Y Puerto Rican	as or No- , etc.)	or No- 14. Race - Amarican Indian, Black, White, etc. Specify: WHITE			
2 ho	ted	15. Decedant's E	ducetion			's Usual Occ	upation na during most	of working	166	o. Kind of Bu	sinass/Indus	stry	
should be filed within 72 hours af administration. The marked other than "neturel", or matic event, the Medical Examination.	Completed	(Spacify only highast gra Elementary/Secondery (0-12) 12	College (1-4or		life. DO	life. DO NOT use retired) Machinist		or working	TI	ruck	Manuf	acturer	
e filed at Hygie other	Be C	17. Fether's Nema (First, Middla, Last	")				18. Mothar	othar's Nama (First, Middla, Maidan Sumama)					
Mental Merked o	To	John		Winghart					eth	L	utcer	kercher	
28 8 8	è	19a. Informant's Name/Relationship (Type, Print) Esther K. Winghart 19b. Mailing Addrass (Straat and Number of 19826 Bennie Drive,											
permit. Peges 1 and Department of Health Important: If Item 27 any Injury or other tr once.		20a. Mathod of Disposition 1								City or Towr	n, Stata		
permit. Peges Department of I Important: If Ite eny Injury or of		21. Signature of Funaral Sarvice Licer	Brake		And	ma and Add	ress of Facility	an Fun	eral Ho	ome, I	nc.	d. 21740	
certificate be executed nding physician and use as the bunel-transit	n/Medical Examiner	Saquantially list conditions, if any, leading to Immediata ceusa. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last	a. Acie b. Duc	Due to (or es e	Consequar	ice oi).	runar	y art	EFY	disea	se		
ette for	iclan/M	Death Other last the second of	d			-							
d by the	Physicia	Part II. Other significant conditions of	contributing to death	out not resulting	in tha unda	nying cause	given in Peti I.					ne cause of death bly 4 ☐ Unknow	
he law requires that the e has been signed by th	Completed by							2	4e. Was en e performed	outopsy d?	availe	e eutopsy findings abla prior to pletion of cause eth?	
9 4 8	Com								1 🗆 Yas	25 No	101	ras 2□ No	
ysicien: The second director, page	Be (25. Was cesa rafarred to madicel axaminar?						of Death (Che	ck only one)				
Physicien: this certific	P	1 ☐ Yas 2 ☐ No	Hospital: 1 Inpat	iant 2 ER/C	Outpatient	3LI DOA		rsing Home	57				
anding P path. r: After t he funera	ation:	27. Manner of Daath 1 ■ Natural 5 □ Panding 2 □ Accidant investigation	28c. In W M 1	juryet Vork? □Yas 2□N	28d. Dascribe how injury occurred								
lor Attending Physicien: The effect death. Director: After this certificate in by the funeral director, pa	Certification:	3 ☐ Suicida 6 ☐ Could not b datarminad	building, a	ijury - At homa, tc. (Specify)					ity or Town, S	State)		Routa Number,	
a si e		29a. Cartifiar 1 Certifying Ph	nysician: To the besi miner: On the basis										
he Hospita in 24 hours he Funeral pletely filled	edical		and manner a	lated.									
To the Hospital or Attending in within 24 hours eiter death. To the Funerel Director: After completely filled in by the funerel completely	Medica	(Check only 2 Medicat Exar		lated.			onsa number	6/		Data signad			
To the Hospita within 24 hours To the Funerel completely filled	Medica	(Check only 2 Medicat Examone)	and manner a	deeth (Item 23e) (Type, Prir	DEVA	0604 RISTO	2 12 1	ARDI	1-19:	98	ıy, Yaar)	



State of Maryland / Department of Health and Mental Hygiene

		Decedent's Nama (First, Middle, La	st)	11 1/0	Certificate o		2. Deta of D Month	Reg. No. eeth Dey	3. Time of Deeth			
Physic /Med		Mary Cat	cherine	Wa	ırner		Januar	y 14, 19	98 8:30 P.M.			
Exami		4a. Fecility Neme (If not institution, giv					or Location of Dea	th 4c. County				
		FREDERICK N 5. Social Security Number 6. S	MEMORIAL HOS	SPITAL In yrs. last bin	hday) If Under 1 Yes	FREDE			REDERICK			
Funeral Director	_		© M 2 □ X = 85		Yrs. Months Dey		8. Data of B (Month, D 7-31-1	912 Y	Birthplece (Stete or Foreign Country) IARY LAND			
e Marylend	ctor	MD. 10b. County FREDERIC		0c. City, Town		JRMONT			10d. Inside City Limits 1 ☐ Yes 2 🕅 No			
th with th	Funeral Director	10e. Street end Number 11238 ANGLEBERGI	ER ROAD		10f. Zip Code 2178			U.S.A				
Fe. Maryland 21215-0020 I and 2 should be filed within 72 hours efter death with the Marylend Health end Mentel Hygiene. The marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No if Yes, Give Yaer or Dates:	13. Was Decedent of If Yes, specify C	as Decedent of Hispanic Ongin? (Specify Yes or Yes, specify Cuban, Maxican, Puerto Rican, atc.) Yas **Tho Specify:			a - American Indien, ck, White, etc. White				
Z1Z13-0UZU d within 72 hours eff jiene. r than "natural", or	Completed	15. Decedent's E (Specify only highest gre Elementery/Secondary (0-12)	ducation de completed) College (1-4or 5+)	Decedent's Usuel Occ (Give kind of work dor life. DO NOT use ret	ent's Usuel Occupation ind of work done during most of working O NOT use retired)			usiness/industry				
and 2121 be filed within itel Hygiene. d other than " svent, in He	Be	7th 17. Fether's Neme (First, Middla, Last, SAMUEL BENTON MA)	MEMAKER	ER 18. Mother's Neme (First, Midd ROSA STOTTLEMY			AKER				
Maryland d 2 should be file th end Mentel Hy 7 is marked oth traumatic svent	To	19e. Informent's Name/Reletionship (Type, Print)		. Mailing Address (Stre	et end Number or	Rurel Route Num	ber, City or Town,				
Party Mark		CLARNECE WM. WAI			11238 ANGLI	EBERGER F	Date Date					
Page ment o		20a. Method of Disposition 1	Removal from State	20b. Plece of Disposition (Name of cemetary, cremetory or other place) MT. OLIVET CEMETERY 1/					City or Town, Stete			
Demit. Depart Import any in		21. Signature of Fungeal Service Later	tules Y	4	1201 N. N	. DAILEY MARKET ST	FREDER	ICK, MD.	DMES, P.A. 21701			
		23e Part1. Enter the disease, or com shock of heart tailure. List only	plications that caused the one cause on each line.	e daath. Do r	not entar tha moda of o	lying, such as card	diac or respiretory	errest,	Approximeta Intervel Between			
Physician /Medical	н	Immediete Ceuse (Final		. ,		0.4			Onset end Death			
Examiner		Immediate Cause (Final disease or condition resulting In deeth) e. NTMACAWAR BUCKED Option of the consequence of the conse										
D #	ner	D.										
icate be executed physician end s the buriel-transit	edical Examiner	Sequentielly list conditions, Due to (or es e consequence of): if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury c.										
\$ 00 °		resulting in death) Last Due to (or es e consequenca of):										
eath cert ettendin	clan	Part II. Other almost conditions			M. a. vanda d. fa a. a. van	alves in Banks	non Di	14abaaaa	manhota to the course of death?			
The law requires that the death cer ale hes been signed by the ettendir page 2 should be deteched for use	by Physician/N	Pert II. Other eignificant conditions of	ontributing to death but n		23b. Did tobacco use contribute to the cause of dea 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unkn							
OI VItal necords, r Physician: The law requires thet this certificate hes been signed to rel director, page 2 should be det	Completed b				24a. Was en eutopsy performad? 24b. Were autopsy available prior completion of of death?							
The law te hes bage 2	ошо						1	Yes 28 No	1 ☐ Yes 2 ☐ No			
	Be	25. Was case referred to medical examiner?					Deeth (Check only	one)				
physic el dire	10	1 ☐ Yes 252 No 27. Menner of Deeth	Hospitel: 1 Inpatient 28a. Dete of Injury	2 ER/Ou	thetieur 30 DOV		g Home 5 Res					
VISION OF VICE Attending Physician: or death. ector: After this certific by the funerel director,	tion	1 Naturel 5 Pending 2 Accident investigation	(Month, Dey Yo		Time of 28c. In V	vork? ☐ Yes 2 ☐ No	200. Describe	how injury occur	190			
2 4 4 5	Certification:	3 Suicide 6 Could not b	8 One Diese of Initial		rm, street, fectory, office	ea .	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)					
To the Hospital within 24 hours or the Funeral completely filled	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of miner: On the basis of exercises of manner stated	aminetion en	, death occurred et lhe d/or investigetion, in m	time, dete end play y opinion, deeth o	ace, end due to the courred et the time	e cause(s) end ma , dete end placa,	anner as steted. end due to the ceuse(s)			
within To the	Me	29b. Signature end title of cartifier	21			insa number		29d. Data signa	d (Month, Day, Yaar)			
		Man:	ple	~	D4	1421	3	1/14	198			
		30. Neme end eddress of person who										
	ate	RAVI YALAMANCHII 31. Data filed (Month, Day, Year)	32. Registrer's	Signeture	MAS JOHNSON	DR. FRI	EDERICK,	MD. 217	701			
St Regist	ate rar	JAN 2 0 19	98	audion	0							
DHMH 16 Rev 6/9	95		0	- Walter	wealth							

1/1/2/2017 1/1/2

Dottie

Certificate of Death 1. Decedent's Neme (First, Middle, Last)
Dottie Mc 2. Dete of Deeth 3 Time of Death **Physician** McNabb Zimmer Month January 19, 1998 4:25 a.m. /Medical 4a. Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Reeders Memorial Home Boonsboro Washington Co. 8. Date of Birth (Month, Dey, Year) Dec. 20,1900 Missouri If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M XX Months Deys 264-80-9709 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director XYes 2□No Maryland Washington Boonesboro 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Items 23a 141 South Main Street USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Meritel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ by 1□ Yes 2□ No Specify: White 3 Widowed 4 □ Divorced "natural", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementery/Secondary (0-12) College (1-4or 5+) 12 Housewife Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) th end Mental F Be Peges 1 end 2 should be nent of Health end Mental Corum T. McNabb Mary Elizabeth Armstrong 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health e Important: if Item 27 is any injury or other trai John Robert "Jack" Zimmer 24256 Oakwood Park Rd., St. Michaels, 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from Stete 4 Donetion 5 Other (Specify) Exeter Cemetery Exeter, Missouri 21. Signature of Funerel Service Presset M 0 0 8 4 9 22. Name end Address of Fecility Snyder Lochstampfor FH Inc Lochstampfor loc hotam 48 S. Church St. Waynesboro, Pa. 17268 Approximete 23a. Pert1. Enter the disease, or complications that ceused the shock, or heart feilure. List only one ceuse on each line. Intervel Between Onset end Death **Physician** Immediete Ceuse (Finel diseese or condition resulting In death) /Medical heart foilure sealine Examiner Due to (or es e consequence of): Examiner b. CAD The law requires that the deeth certificate be executed an Meure Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? yd bengis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown failure Division of Vital Records, þ 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? 1□ Yes 2€ No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this 28c. Injury et Work? 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) Medical Certification: 28b. Time of 28d. Describe how Injury occurred After 5 Pending 1. Naturel death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 ☐ Sulcide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) à 4 Homicide To the Hospital
within 24 hours of
To the Funeral C the Hospital Critifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

| Continue of the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated. (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D32518 1 MD 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Dr. Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/301-432-2222 31. Dete filed (Month, Day, Year) State

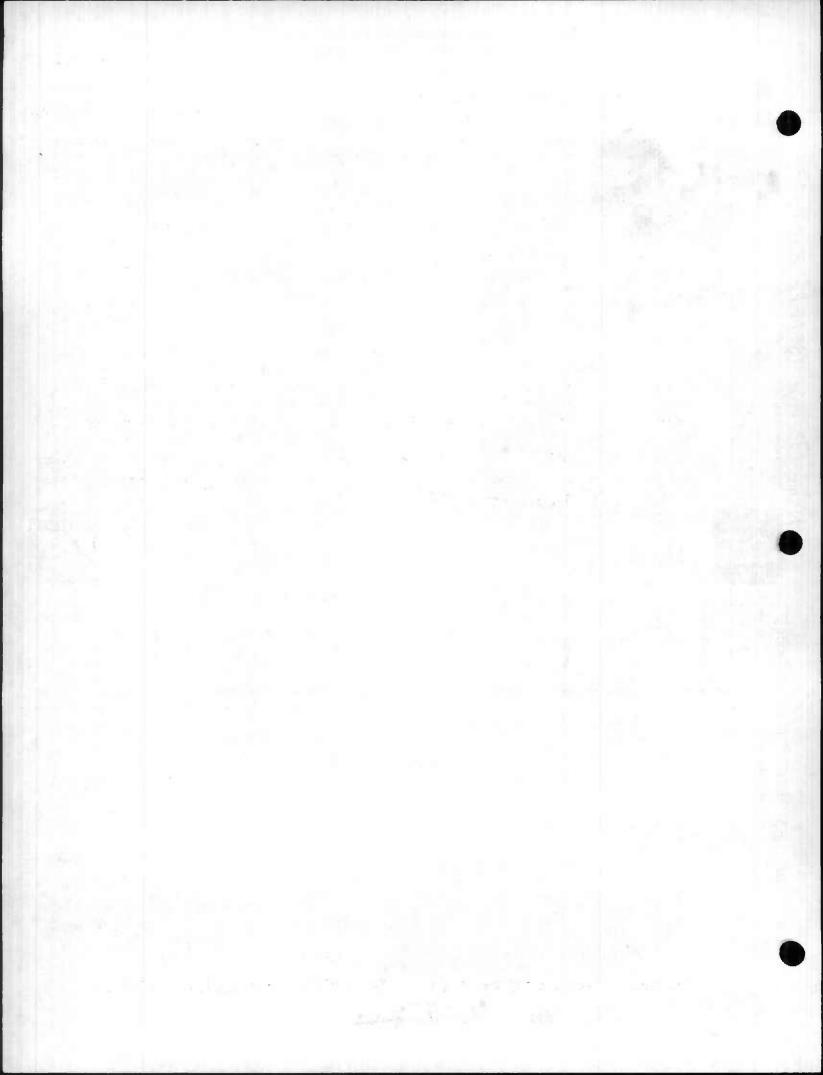
Julia Davidson

JAN 2 3 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 10:57am HNDERSON JANUARY /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA MEDICAL CENTER If Undar 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yaar 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 10M 20 F Months Deys Hours 215-96-1418 2 Yrs April 25, 1945 Usual Rasidanca of Decadent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Mo Director AG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 340 21217 USA IMES HUE. Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Reca - American Indian, Black, Whita, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☑ No þ f Yes, Give raar or Datas: 3 ☐ Widowed 4 ☐ Divorced lac Completed 18a, Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12+1 NA ENVIRONMENTA HSSOC. SINAI 17. Fethar'a Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be INDERSON 2 ENNIE NON taquac 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ENNIE ANDERSON-Ave Mother Ho Ho. 20b. Piece of Disposition (Name of cemetery, cramatory or other piece) 20e. Method of Disposition Dete Location - City or Town, Stata 1 ■ Buriel 2 □ Cremetion 3 □ Ramovel from Stete and 4 ☐ Donation 5 ☐ Othar (Specify) EMO 21. Signature of Funaral Sarvice Licensaa 22 Nama and Addrass of Facility Home gral Ho. FUNE m C. March 4300 Wabash Ane. 21215 Tarris 23a. Part. Enter the disease, or complications that caused the death. Do not anter tha mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Death immediete Ceuse (Finel diseese or condition resulting in deeth) Due to (or es e consequence ot): HNEMIF Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseesa or injury that initiated events resulting in death) Last Dua to (or es a consequence of): Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy tindings aveilable prior to completion of cause of deeth? 24a. Wes en autopsy performed? 1 🗆 Yes 2 No 1 🗆 Yes 200 No 25. Wes case referred to medicat 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatlant 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Invastigation 1 Neturel 1 Yes 2 No

Physician /Medical Examiner

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Heelth end Mantel Hygiene. Important: if Item 27 is marked other than "nature!", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examples invalled at

Baltimore, Maryland 21215-0020

the Maryland

Examiner Physician/Medical þ Completed Be Certification: To

attending physician end for use as the burial-transit certificete be executed Box 68760. signed by the a Records, P.O. been si has раде 2 certificate Division of Vital tal or Attending Physician: The offer deeth.

Signature of the offer this certificate of in by the funeral director, page in by the funeral director, page of the offer e Funeral Di Hospital within 24 ho To the Fune completely fi

> State Registrar

Medical

29b. Signeture end titia of certifian

6 Could not be datermined

29c. License number

HEIGHTS HVENUE

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, daeth occurred at the time, date end place, and due to the cause(s) and menner steted.

29d. Date signed (Month, Day, Year)

BALTIMORE MD 21215

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

30. Name and address of person who completed cause ot deeth (Item 23a) (Type, Print)

31. Dete filed (Month, Dey, Year) FEB 0 2 1998

2 Accidant

3 Suicida

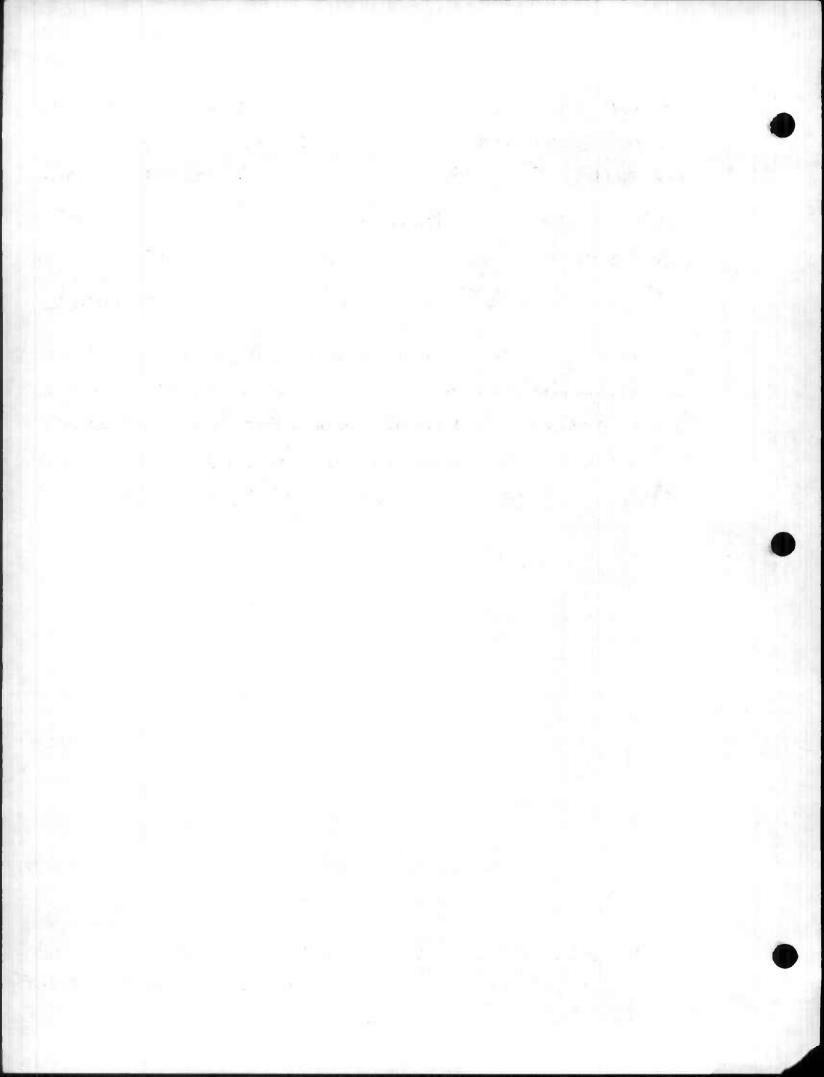
29a. Certifier

4 Homicide

(Check only one)

LI DERTY 's Signature Davidson

Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)



KAR 98-052-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. MICHAEL State of Maryland / Department of Health and Mental Hygiene ABBOTT Certificate of Death Items: 23a part I,27,28a-f per MEO G-756 2/5/98 dh Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Time of Deeth **Physician** MICHAEL JOSEPH ABBOTT 29, 199 4c. County of Death 1998 8:32P.M JANUARY /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner n/a 1708 LIGHT STREET APT#24 BALTIMORE
If Undar 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) 9. Birthplece (Ste Country)
March 25 1954 Maryland 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min. 1X M 2□ F 217-62-7620 43 Yrs. Director Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or thems 23s or 28s-f show traumatic event, the Medical Examinations to notified at 1X Yes 2 □ No Director Md. n/a Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1708 Light Street 21230 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 Ia marked other than "natural", or Itema 23.
Iny or other traumatic event, the Medical Example of the country. Funeral 14. Rece - Amarican Indien. 12. Was Decedent Evar In U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give Vietnam Year or Dates: 1 X Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: white P 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Collaga (1-4or 5+) Elementary/Secondary (0-12) n/a unemployed 12 18. Mothar's Name (First, Middle, Melden Surneme) 17. Father's Name (First, Middle, Last) Be Margaret Abbott Dwight Cabbs 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 7851 Outing Ave. Pasadena, Md. 21122 Margaret J. Johnson (Mother) Baltimore, 20e. Method of Disposition 20b. Place of Disposition (Nema of cemetery, cremetory or other place) Date 20c. Location - City or Town, State Feb. 2 1 ☐ Burial 2 Cremetion 3 ☐ Removel from Stata Department of Important: If any injury or Metro Crematory Inc. Catonsville, Md. 4 Donetion 5 Other (Specify) 1998 21 Signature of Funeral Service Licensee 22. Name end Address of Fedility McCully-Polyniak Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230 23a. Pert . Enter the diseesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Intervel Between Onset end Death **Physician** Immediate Cause (Finel disaese or condition resulting in daath) /Medical NARCOTIC AND ALCOHOL INTOXICATION Examiner Due to (or es e consequence of): Examine burial-transit Sequantially list conditions, if eny, leeding to immadiete causa. Entar Undarlying Cause (Disaase or Injury that initiated evants resulting in death) Lest Due to (or es e consequence of): physician s the buria Box 68760 Physician/Medical Due to (or as e consequence of): SE USB 0 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? O 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. À 24b. Were eutopsy findings available prior to 24a. Was an eutopsy Completed completion of causa of deeth? page 2 s has 1 -Yas 2 No 1 ☐ Yas 2 ☐ No cartificate Hospital or Attending Physician: director, 25. Was case referred to medice! examiner? Be 26. Place of Death (Check only ona) To Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Spacify)

Injury et 28d. Dascribe how Injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28c. Injury et Work? funeral 27. Mannar of Death P Certification: 28e. Date of Injury (Month, Dey Year) 28b. Time of 1 Natural 5 Pending 1 Yes 2XXNo death. investigation 2 Accidant found: 1/29/98 8:30 unknown after deat Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Straet and Number or Rural Route Number, City or Town, Stata) Baltimore, Maryland 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida AT HOME found:residence 24 hours a 1708 LIGHT STREET APT#24 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the tima, date end place, and due to the cause(s) end menner es stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner stated. 29a. Cartifier To the Hosp within 24 hou To the Fune completaly fi Medical

29c. License number

O.C.M.E.

29d. Data signed (Month, Dey, Year)

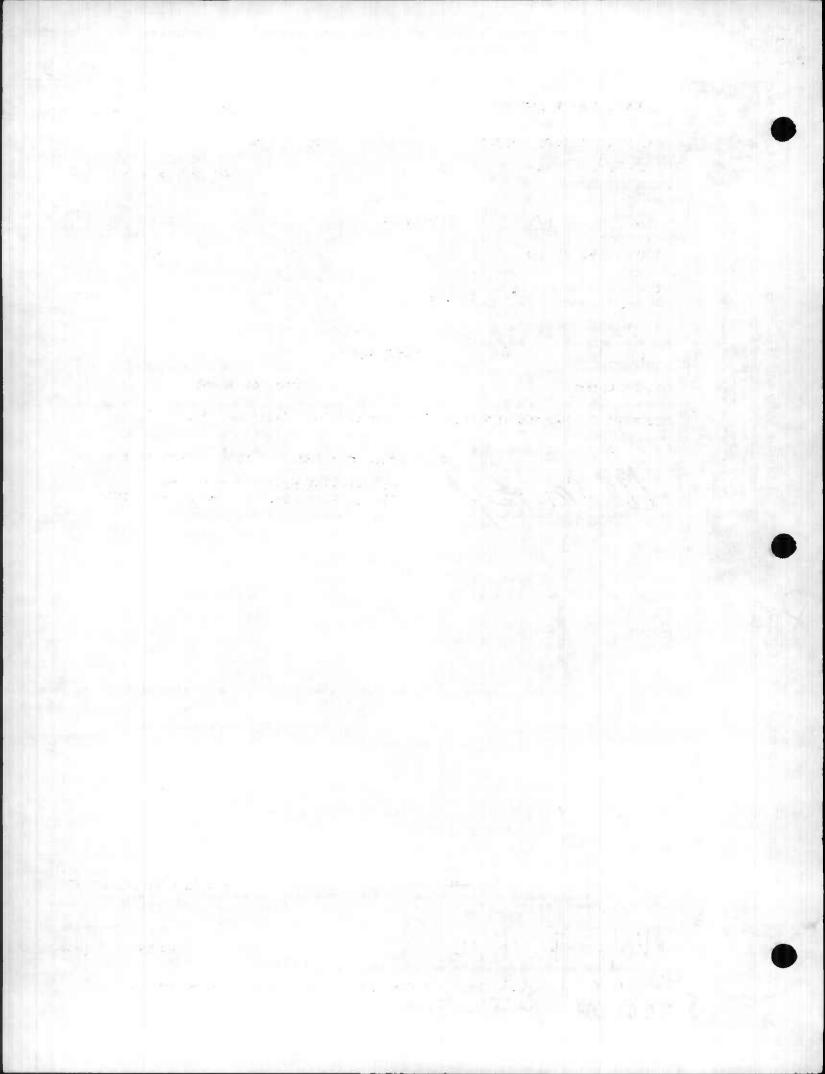
JANUARY 30, 1998

State Registrar 29b. Signature end title of cartifiar,

MARYDRUPS

A. Kololum 111 Penn Street, Baltimore, Maryland 21201 31. Data filed (Month, Day, Year) FEB 0 2 1998

30. Nema end address of person who completed cause of deeth (Item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month THOMAS BOLEWICKT JANUARY 27,1998 10:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** RIVERVIEW NURSING CENTRE, INCORPORATED BALTIMORE BALTIMORE 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 1,1908 9. Birthplace (State or Foreign Country) Maryland **Funerai** 1 M 2 □ F Hours 214-03-2056 89 Director Usual Residence of Decedent 10a State 10b. County ns 23a or 28a-f show must be notified at 10d. Inside City Limits Baltimore Maryland Director Dunda1k 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Apt. B 21222 United States 2904 Dunmore Road Herris 23a Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Detes: 14. Raca - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married "natural", or timore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White by Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Manufacturing Assembler 8 Years permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: If Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Ziomkowski James Bolewicki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3427 Walnut Road Aberdeen, Maryland Alice Hardy / Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Schwartz Cemetery 1/30/1998 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that daused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or haart failure. List only one cause or each line. Approximete Interval Between Onsat and Death **Physician** Immadiate Cause (Final disease or condition resulting in death) /Medicai Atherosclerotic cardiovasular disease Examiner Due to (or es e consequença of): abetes mellitus

Due to (or as e consequenca of): Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Box 68760. ne Phropattu Physician/Medical Part II. Other algniftcant conditions contributing to death but not resulting In the underlying cause given in Part I. P.0. been signed by the should be deteched 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, þ 24b. Wara autopsy findings aveilable prior to complation of cause of daath? Completed 24a. Was an autopsy performed? of myocardial infaction 1 Yas 2 No Division of Vital 25. Was casa raterrad to medical Be 26. Place of Death (Check only ona) 1 ☐ Yas 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending 1 Natural s efter des. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral 29a. Cartifier 1 🔀 Certifying Physicien: To tha best of my knowledga, deeth occurred at the time, date end place, end due to the cause(s) and mannar as stated. Medicai To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46082 N. Desupandem D 30. Nama and addrass of parson who complated cause of death (Itam 23a) (Type, Print) NEETA DESHPANDE, M.D. IEASTERN BLVD. BALTIMORE

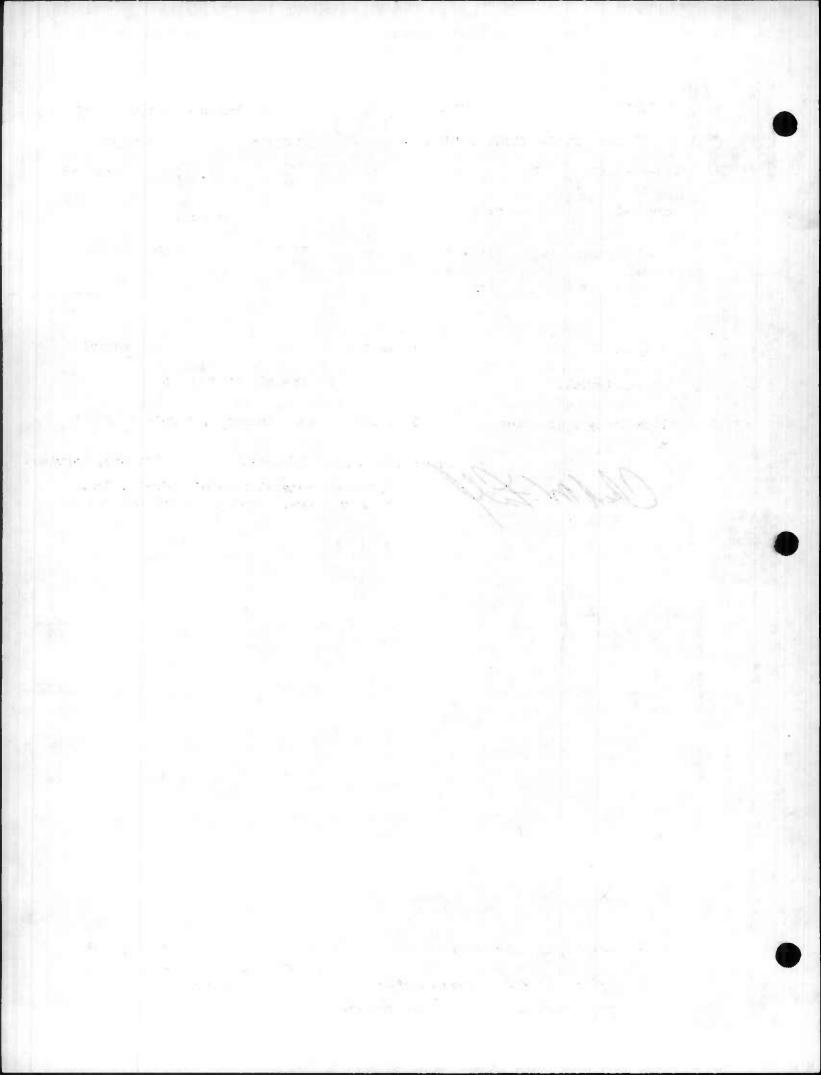
32. Ragistrar's Signature

MD 21237

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)



Examiner the death certificate be executed Box 68760, Records, P.O. Division of Vital or Attending Hospital

Physician

/Medical

Examiner

Funeral Director

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Completed

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2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P11389 MD Feb. 2.

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State Registrar

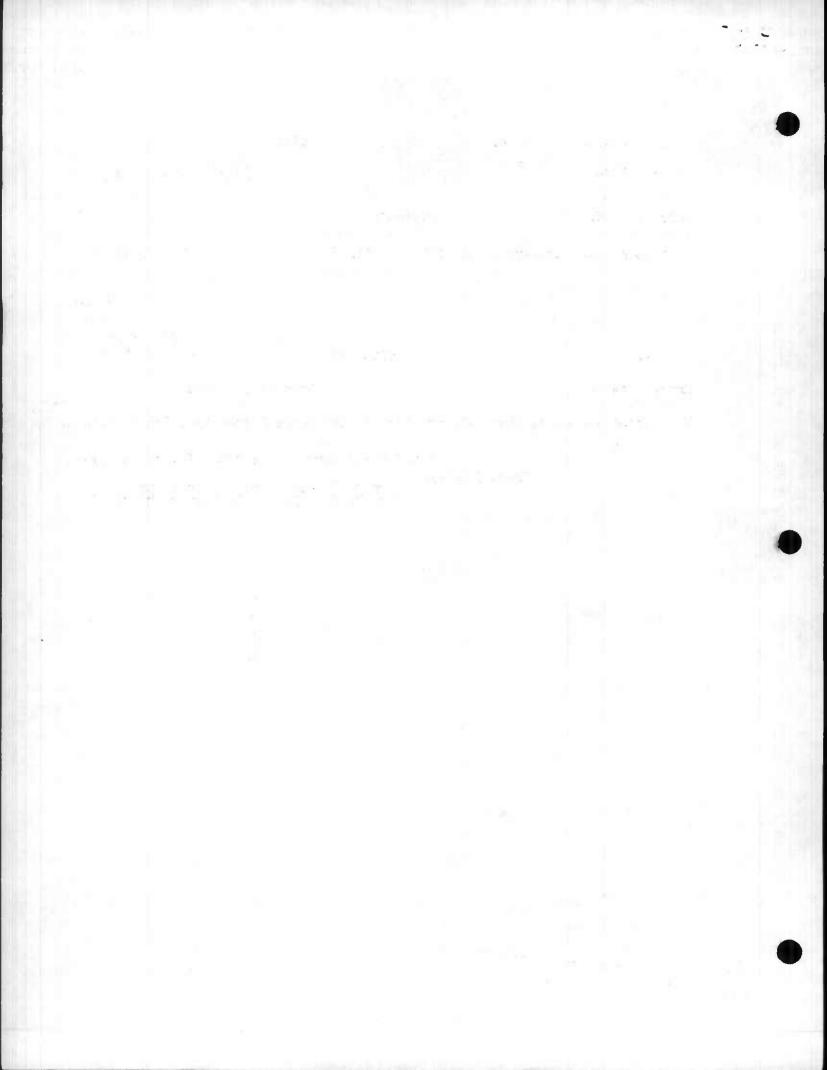
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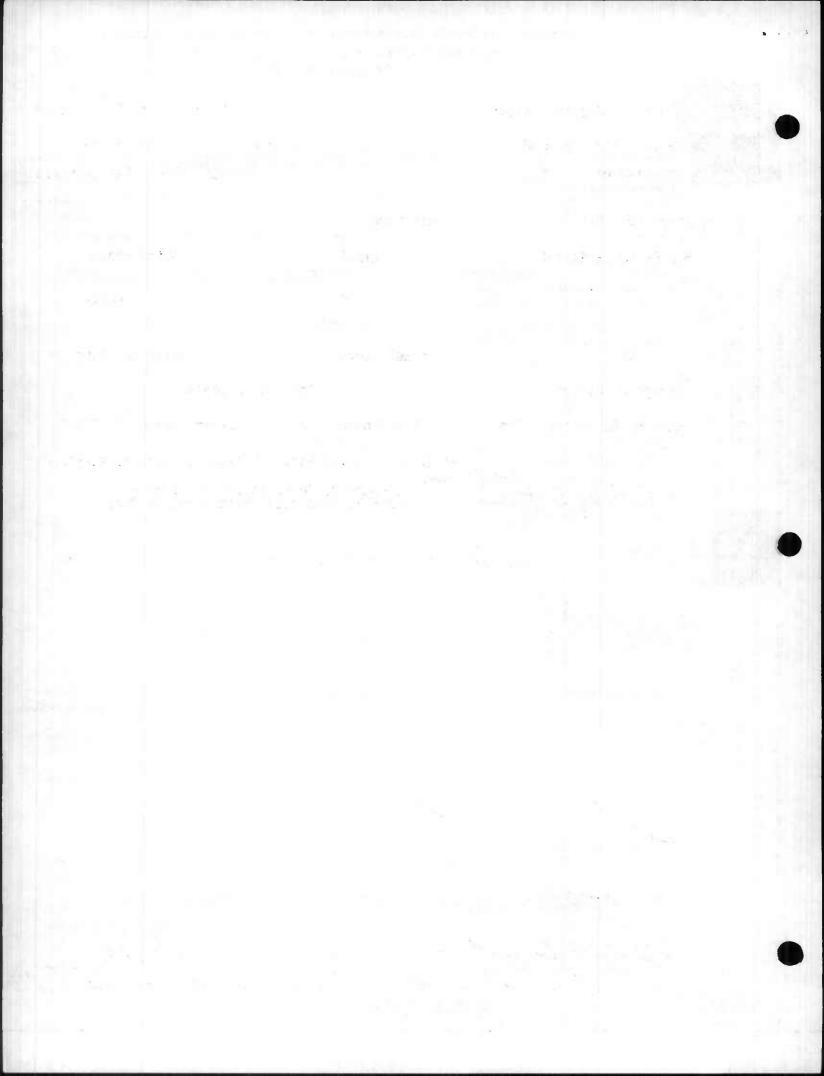
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 3 8 0 2 5 6 2

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State of Maryland / Department of Health and Mental Hygiene 9

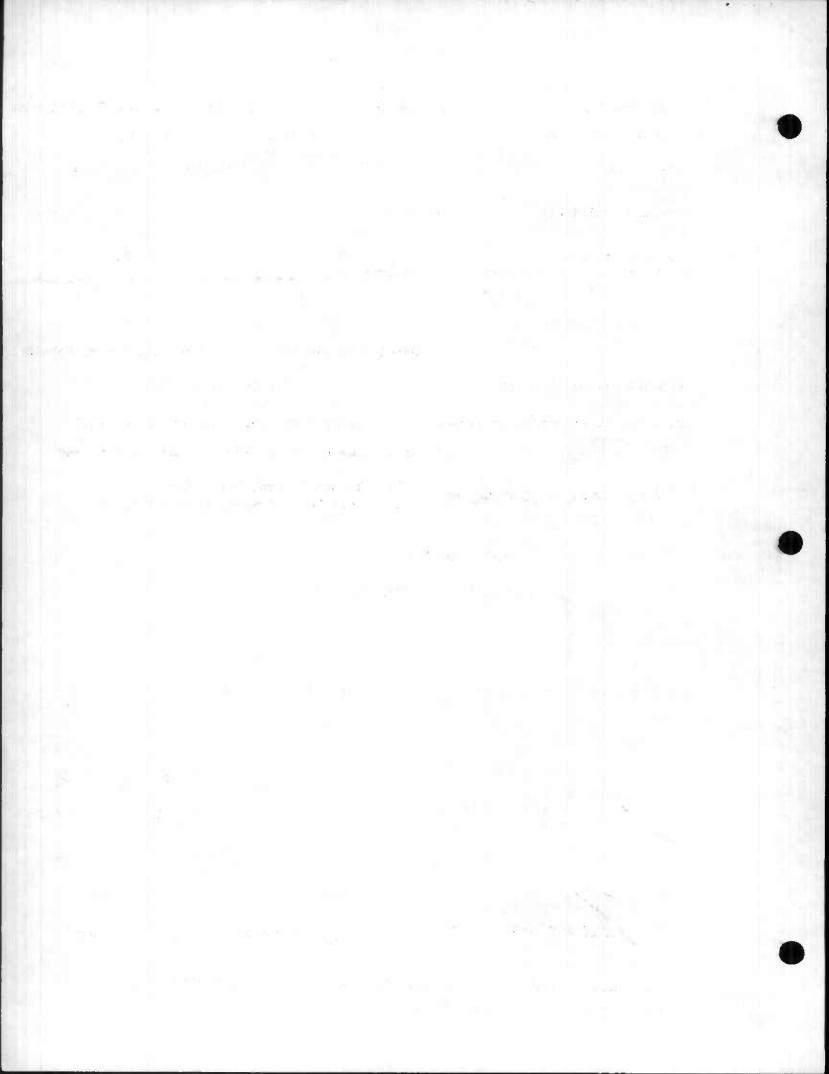
Certificate of Death 1. Dacadent's Nama (First, Middla, Last) 2. Date of Death 3. Tima ot Death **Physician** Month Yaai **JEANNETTE** BONGARDT JANUARY 30, 1998 12:50pm /Medical 4a. Fecility Nema (If not institution, giva streat and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore 5. Social Sacurity Number If Undar 1 Year if Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 8-18-1940 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funerai** Days Hours 1□M 2√2F 214-38-5097 Yrs Director Maryland Usuai Rasidanca ot Dacadant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Baltimore Maryland Fallston Director 1 ☐ Yes XIX No 10a. Straat and Number 10f, Zip Coda 10g. Citizan of What Country? 3208 Ascot Lane 21047 Funeral U.S.A. 12. Was Dacedant Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Bieck, Whita, atc. 11. Maritai Status 1 ☐ Yas ZX No It Yas, Giva Yaar or Dates: 1 Nevar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedant's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) a filed within 7 al Hygiene. Elamentary/Secondary (0-12) Coliaga (1-4or 5+) Medical Technologist Franklin Square Hospital 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be 2 should be fi and Mental F Francis E. Sliwka , Sr. is marked Sophie Misciwojewski 2 permit. Pages 1 and 2 ah. Department of Health and Important: If item 27 is me any injury. 19e. Intormant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Straat end Number or Rural Routa Number, City or Town, Stata, Zip Code) Mr. James E. Bongardt, Sr. (Husband) 3208 Ascot Lane, Fallston, Maryland 21047 20a. Mathod of Disposition 20b. Place of Disposition (Nema of Data 20c. Location - City or Town, Stata cematary, crematory or other place)
Holy Roasary Cemetery 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 2-2-98 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signatura of Funaral Sarvice Licensea 22. Name end Addrass of Facility Ruck Towson Funeral Home, Inc. allace 5 Brooks, & 1050 York Road, Towson, Maryland 21204 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heer feilura. List only one cause on each line. Approximata Interval Batw Onsat and Death **Physician** /Medicai Immedieta Causa (Final RENAL CANCER disaasa or conditio resulting in daath) Examiner Due to (or as a consequence ot): Examiner METS TO ABDOMEN AND LUNG bunial-tran Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or injury that initiated events resulting in daath) Lest and Dua to (or as a consequence ot): physician s the bunal Box 68760 Physician/Medical Due to (or es a consequenca of) attending use 0 per Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert t. P.O. 23b. Did tobacco use contribute to the causa of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Wara autopsy findings evailable prior to completion of ceusa of death? 24a. Was an autopsy performad? Completed been has page 1 Yas 2 No certificate 1 ☐ Yes 2 No Division of Vital after death.

Director: After this certifications director. 25. Was cesa raterred to medicel Be 26. Placa of Daath (Check only ona) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Yas 2 No 2 funeral 28a. Data ot Injury (Month, Day Year) 27. Mannar of Death Certification: 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Panding 2 Accidant 1 TYas 2 No invastigation 6 Could not be datarmined 3 Suicide 28a. Place of Injury - At homa, tarm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicida Hospital of 24 hours a Funeral D Certifing Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) To the F within 2. To the F complet 29d. Data signed (Month, Day, Yeer) 29b. Signatura endaitie of certifies for the 30 C 30. Nama and address of person who completed ceusa of death (Itam 23a) (Type, Print) DR. EDDIE NAKHUDA, 2300 DULANEY VALLEY RD., TIMONIUM, MD 21093 32. Rogistrar's Signatura 31. Data tilad (Month, Day, Yaar) State B 0 2 1998

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death Iyems:2,26 per MD G-756 2/2/98 dh 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 1/13/98 Yee 3. Time of Death **Physician** Month 13 1988 William J. Brown January 7:15 A.M. /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Baltimore Veterans Affairs Hospital Baltimore If Under 24 Hrs. If Under 1 Year Funeral 6. Sex X M 2□ F 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) Months Deys Hours Min Yrs. Director 141-16-8825 Oct.6 1921 Baltimore Md. Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland N/A Baltimore 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? ò items 23a 3600 Reisterstown Rd. death Funeral 21215 12. Wes Decedent Ever In U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Dates: 42 – 46 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 nd Mental Hygiene. marked other than "natural", or 1 ☐ Yes 2 🔯 No Specify þ Specify: 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Construction Work Forman 17. Fether's Neme (First, Middle, Last) permit. Peges 1 and 2 should be file Depertment of Health end Mental Hy Important: if Itam 27 Is marked other any Injury or other traumatic event once. 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Unknown Almedlia Moreland 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Hilda Brown 3600 Riesterstown Rd. Balto, Md. 21215 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 1XXBuriel 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Cemetery 1/20/98 Owings Mill, Md. rvice Licenses 22. Name end Address of Fecility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, Md. 21217 Palm Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediete Ceuse (Finel disease or condition resulting in death) /Medical CONFESTIVE HEART FAILURE Examiner Due to (or es e consequenca of): The law requires that the deeth certificete be executed pue Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of): for use es the buriel-Box 68760 Due to (or es e consequence of) signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death?

Physician/Medical þ Completed Be (Certification: To

Medical

29b. Signeture end title of certifier

LEIGH BOYLUARE

31. Dete filed (1/24) Dey, Year) 1998

pege 2

Hospital or Attending Physician: 24 hours effer death.
Funeral Director: Affer this certifica etely filled in by the funeral director, p

To the Hospital of within 24 hours of To the Funeral D completely filled

Records,

Division of Vital

1 □ Yas 2 □ No 3 □ Probably JUnknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 XX npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deet 28e. Dete of Injury (Month, Day Yeer) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one)

29c. License number

P09727

29d. Date signed (Month, Dey, Year)

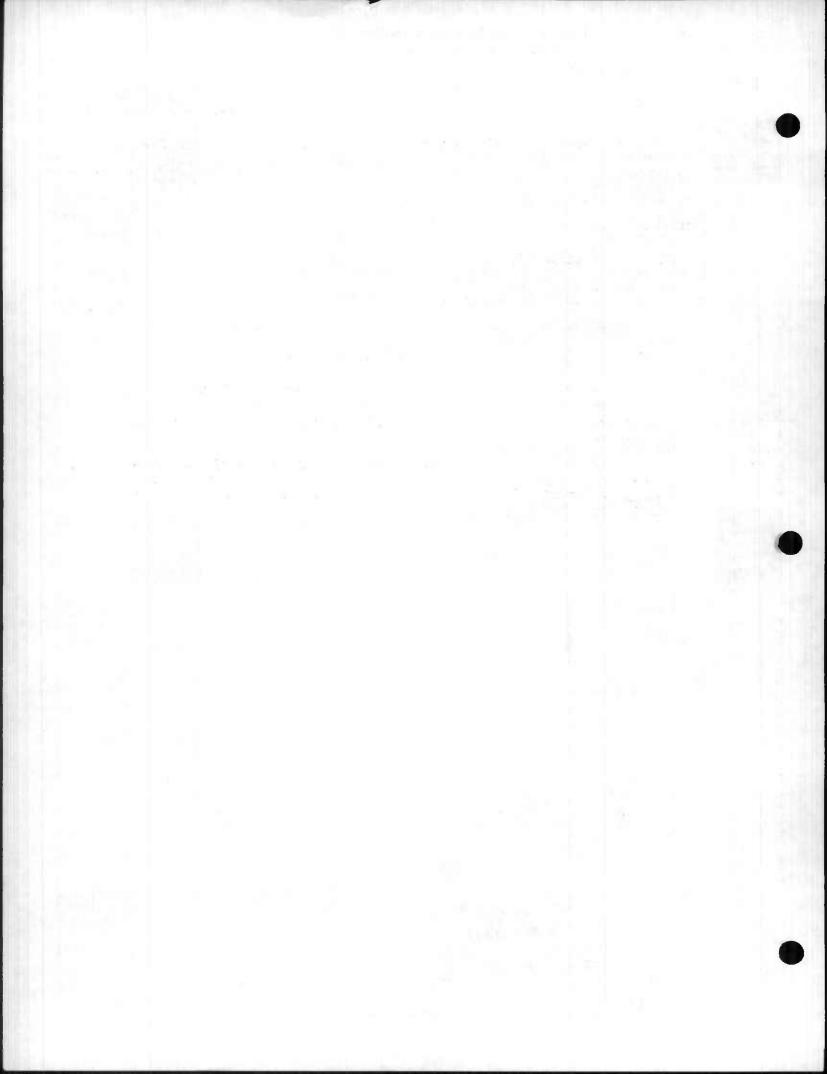
1998

January 22,

State Registrar 10 North Greene Street Baltimore, Md. 21201 intrara Signature

(Bomars)

30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)



98-0442-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene 9 KENNETH ALFRED Certificate of Death BARNES 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician JANUARY** 29,1998 00:42 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SHOCK TRAUMA UNIT If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) **Funeral** Months 10 M 20 F Days Hours 216-84-7131 Usuel Residence of Decedent 216 Yrs. Director 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho 1 ☑ Yes 2 ☐ No Director nary/And 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 4301 21229 ArdeN Funeral 9 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, 11. Marital Status Black, White; etc. should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 1 ☐ Nevar Married 2 ☐ Married Maryland 21215-0020 1 Yes 2 1 No Specify: þ 3 ☐ Widowad 4 ☐ Divorced HMEYICAN Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry a most of working BWI -Dollar Rent ACA Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 210 gen! other 18 Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be h end Mental I 0 Kenneth Deboran 19a. Informent's Name/Relationship (Type, Plat) (Mo They) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 st Department of Health end Important: If Item 27 is in any Injury or other traur 20b. Place of Disposition (Neme of cemetery, crematory or other place) 120a. Method of Disposition 20b. F 21224 BAITIMORE altimore, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State DAllimore 4 ☐ Donation 5 ☐ Other (Specify) TAIK UNETA 21. Soniture of Funeral Service Licenses 22. Name and Address of Ricility 55 Hom Entar the disease, or complications that caused the death. Do not enter the not one of the control of the contr , NorThHUE, ISAI md. 21216 Approximate Interval Between Onset and Death moda of dying, such as cardiac or raspiratory arrest, Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Examiner certificate be executed burial-tran Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Box 68760 physician Physician/Medical the Due to (or as a consequence of) 98 9SN signed by the a d be detached f 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 19 Yes 2 No 197es 2□ No 25. Was cese referred to medical examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 X Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 Netural subject Shot 13 1 ☐ Yes investigation -99 16 2 Accident Location (Street end Number or Rurel Route Number, City or Town, Stete)

Division of Vital Records. after death. ò Hospital of 24 hours a Funeral D

To the F

State

Registrar

edicai

10010 31. Date filed (Month, Dey, Yeer)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) towler

Street

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Medicat Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated.

OCME

29c. Licensa number

2000

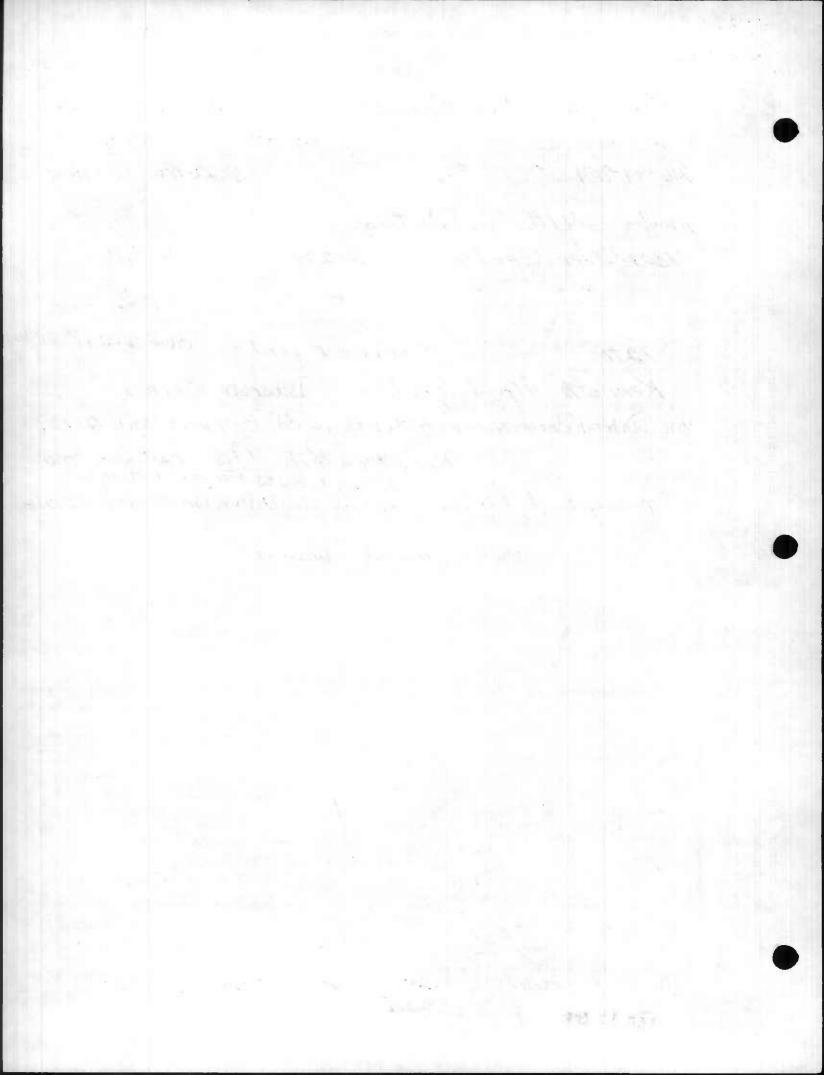
when

29d. Data signad (Month, Dey, Yeer)

JANUARY 29, 1998

ave

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certifica	ate of Death	Reg	. No.	02566		
Physici	an	1. Decedent's Name (First, Middle, Li	15()	Bood		2. Date of Death Month	Day	3. Time of Deat		
/Medic		4a. Facility Name (I not institution, gi	ve street end number)	DIOCITE	4b. City. Town,	or Location of Death	4c. County	1998 7:48 p		
Funeral Director	iei	University 5, Social Security Number, 1 6.	of Maryla	nd Hospi- s. lest birthday) if Unc Yrs. Month	Fall Baller 1 Year If Under 24 H	tmore rs. 8. Date of Birth	N 9940	9. Birthplace (State or Form		
28a-f show	Director	10a. Stele 10b, County	10c. C	City, Town or Location	E			10d. Inside City Lin 1 Yes 2 □		
23a or 28a-f show	ral Dire	2132 W. FF	YEHE S	T. á	1223		Citizen of	Whet Country?		
Hygiene. the than "natural", or items 23s or 28s-1 show ont, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		edent of Hispanic Origin? ecify Cuban, Mexican, Pu- 212 No Specify:	(Specify Yes or No- erto Rican, etc.)		ca - American Indien, ck, White, etc. y: BLACK		
jiene. r than "natural", tre Medical Exe	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ede completed) College (1-4or 5+)	16e. Decedent's Us (Give kind of v life. DO NOT	vork done during most of w	vorking 16	b. Kind of B	usiness/industry		
o do	To Be Co	17. Father's Name (First, Middle, Last	ame (First, Middle, Me	iden Sumen	ne)					
n 27 is merke n 27 is merke ner traumatic		19a. Informant's Name/Relationship	VEAD	2132	ss (Street end Number or U. Fayett)	Rurel Route Number, C CSt. Ba	LT. N	State, Zip Code)		
ment of Hi lant: If lien jury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation □ Other (Specia	Removal from State	Placa of Disposition (N cemetery, crematory of 7. Z/ON	eme of other place) EMETERY	1/3998 L	C. Location -	City or Town, State WNE, MD		
Depart Import any in gass		21. Signature of Anural Sag of Lice 23a, Palvi. Er exhaussease, or com shock, r y ert failure. List only	and	22 Nagra	PREDNIL	TON MASS	BAL	ME 814		
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been signed by the ettendin should be deteched for use	by Physician/	Part ii. Other algnificant conditions of	ontributing to death but not re-	sutting in the underlying	cause given in Part I.	23b, Did tobe	2 No	ntribute to the cause of de		
SC	Completed		R. C. Jr. St.			24a. Wes en a performe	utopsy d?	24b. Were eutopsy findin evallable prior to completion of cause of death?		
is certificate he director, page		05 18/20 20 20 20 20 20 20 20 20 20 20 20 20 2				1□ Yes	2 No	1 ☐ Yes 2 ☐ No		
s certi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□ 0	Other		h (Check only one) me 5 ☐ Residenca 6 ☐ Other (Specify)			
		27. Manner of Death 1. Natural 5 Pending investigation	28a. Dete of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	-			
800	Ĕ	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ry, offica	28f. Location (Stree City or Town, S	28f. Location (Street end Number or Rural Route Number, City or Town, State)				
urs efter death.										
n 24 hours efter des ne Funeral Diractor sletely filled in by th		29a. Certifier 1 Certifying Ph	yalclan: To the best of my known the common stated.	owledge, death occurrent ation end/or Investigation	d at the time, dete and place n, in my oplnion, death occ	ca, and due to the caus curred et the time, dete	e(s) and me and place,	enner es steted. end due to the ceuse(s)		
in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one) 29b. Signature and title of cartifier **Latura**	niner: On the basis of examina	ation end/or Investigatio	n, in my opinion, death occ	curred et the time, dete	Date signed	enner es steted. end due to the ceuse(s) d (Month, Dey, Year) LY 24,199 Baltimore, 1		

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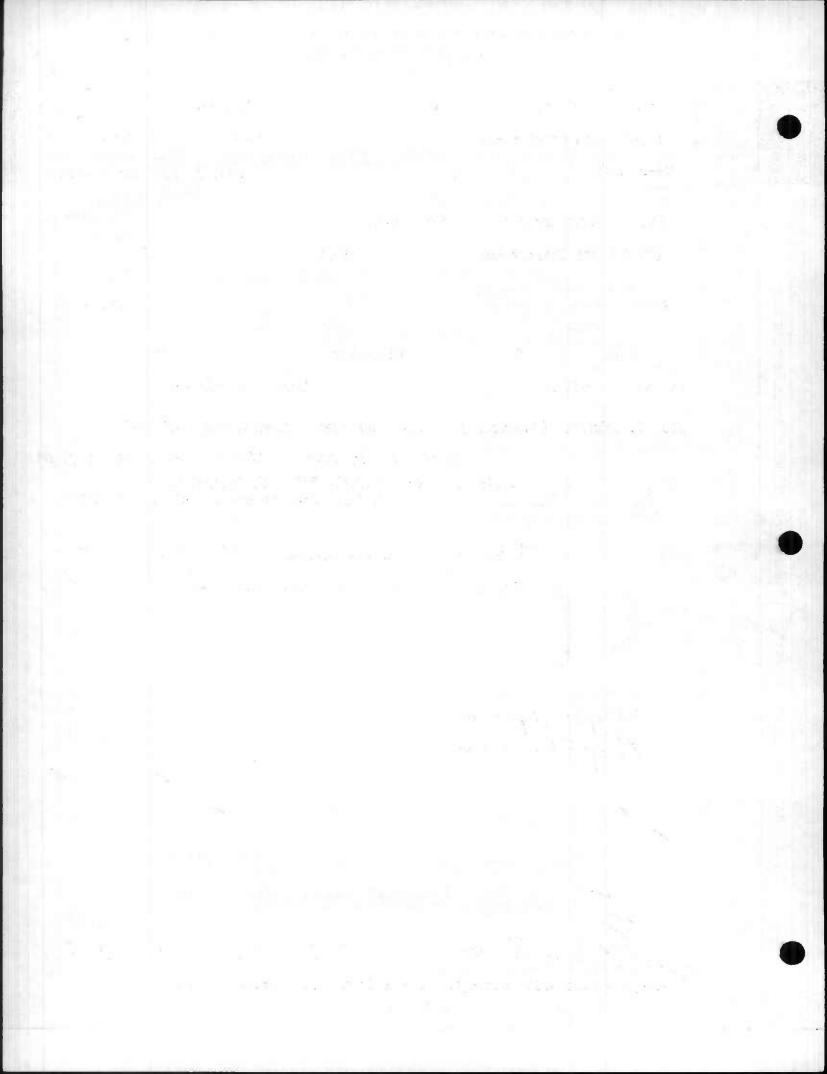
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Department of Health and Mental Hygiene

	Certificate of Death	Re	g. No.	19670
Physician	Decedent's Neme (First, Middle, Last)	2. Dete of Deet	Day V	3. Time of Deeth
/Medical	Sara Marie Baker	Jan. 28,	1998 Y	11:00 P.M
Examiner	4e. Facility Nema (If not Institution, give street end number) 4b. City, Town, 103-D South Charter Road Glen E	or Location of Daath	Anne A	
neral ector	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24		Year) 9.	Birthplace (Stete or Foreign Country)
	Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
by Funeral Director	MD. Anne Arundel Glen Burnie			1 ☐ Yas 2 € No
Director	10e. Street end Number 10f. Zip Code	10	Og. Citizen of Whe	t Country?
a	103-D South Charter Road 21061		U.S.A	
by Funeral	11. Marital Status 12. Was Decedant Ever in U,S. Armed Forces? 1 Never Merried 2 Married 3 Widowad 4 Divorced 12. Was Decedant of Hispanic Origin If Yes, specify Cuben, Maxican, P 1 Yes, Give Yaer or Dates:	? (Specify Yas or No- ruanto Rican, etc.)		American Indian, White, etc. White
Completed	15. Decedent's Education (Specify only highest grada completed) [Giva kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Busin	
mple	College (1-40r 5+)	WOIKING		
	12th 0 Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's	Name (First Adiable A	Home	
Be Se		Neme (First, Middle, N tta (Unkno		
10	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number of			to Zin Code)
	Joan T. Schmidt (Daughter) 8332 Dock Road Pasa 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place)	dena, Mary	land ZIII 20c. Location - City	y or Town, State
	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Greenmount Crematory	1/30/98	Baltimor	e, Maryland
any injury				-, ·
once	21. Signeture of Funeral Servica Licensee Kevin E. Ecker 22. Name and Address of Facility - Polyin 237 E. Patapso			ld 21225
	23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.			Approximata Intervel Between
ian cal ner	Immedieta Cause (Finel disease or condition resulting in deeth) e. There are a consequence of):	Ruj	plure	Onsat and Death
ner	Therocie Hartie Xn	eux(sw		8/9,
Examiner	U. The state of th			
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events Due to (or as a consequence of):			
Medical	that initiated events resulting in deeth) Last Dua to (or as a consequenca of):			
	d			1
clan				
Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did to		outs to the cause of death?
	Nypaglycemia	15Ye	s 2□ No 3[☐ Probably 4 ☐ Unknown
Completed by	Nypotensian	24a. Wes er perform		4b. Were eutopsy findings aveileble prior to completion of cause of deeth?
Com	V	1 □ Ye	s 2 No	1 ☐ Yes 2 ☑ No
Be	25. Wes case referred to medical exeminer?	Deeth (Check only one	в)	
2	1 ☐ Yes 2 ☑ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursin	ng Home 5 PReside	nca 6 DOther (Specify)
Certification:	27. Manney of Deeth 1 Maturel 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work? 1 Yes 2 No 28c. Injury et Work? 1 Yes 2 No	28d. Describe ho		
	4 ☐ Homicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Str City or Town	reet end Number o , Stete)	or Rural Route Number,
	29e. Certifier (Check only one) 1 Certifying Phyelclan: To the best of my knowledge, death occurred et the time, dete end properties of the best of exeminers on the best of exeminers on the best of exeminers on the best of exeminers on the best of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, dete end properties of my knowledge, death occurred et the time, determiners of my knowledge, death occurred et the time, determiners of my knowledge, death occurred et the time, determiners of my knowledge, death occurred et the time, determiners of my knowledge, death occurred et the time, determiners of my knowledge, death occurred et the time, determiners of my knowledge, death occurred et the time, determiners of my knowledge, death occurred et the time, determiners of my knowledge, death occurred et the time, determiners of my knowledge, death occurred et the time, determiners occurred et the time, determiners occurred et the time, determiners occurred et the time, determiners occurred et the time,	lece, end due to the ce occurred et the time, de	ouse(s) end menne ete end place, and	er es steted. due to the ceuse(s)
Me Me	29b. Signature and title of certifier 29c. Licensa number	29	d. Data signed (N	fonth, Day, Year)
	1 500 DW D319	44	1-0	29-98
	10. Name and address of person who completed cause of death (Item 23e) (Type, Print)			
0	George Hebard 4710 Pennington Avenue Baltimore, Ma	anuland 212	226	



PAUL BOLANDER

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

111 Penn Street, Baltimore, Maryland 21201

Box 68760, the sta # 885 à Division of Vital Records, P. signed t page 2 confilcate 19 Attanding all a ò

Certificate of Death Reg. No 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dey **Physician** PAUL ALLEN BOLANDER 0944 AM JAN. 30, 1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner HARBOR HOSPITAL E.R. BALTIMORE N/A | H Under 1 Yeer | H Under 24 Hrs. | 8. Dele of Birth (Month, Dey, Year) | 9. Birthplece (State (Month, Dey, Year) | 9. Birthplece (State (Month, Dey, Year) | 1954 | Maryland 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 11XM 2□ F Yrs. 215-48-2845 43 Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show Md. Anne Arundel Co. Linthicum 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with r than "natural", or items 23s or the Medical Examiner must be 221 Coronet Drive 21090 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or frems 23a says Injury or other traumatic event, the Medical Examples PARE. Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Advanced Marine Elementary/Secondary (0-12) College (1-4or 5+) Enterprises Inc. Engineer 12 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be John W. Bolander Jr. Elizabeth E. Marshall 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Donna M. Bolander (Wife) 221 Coronet Drive, Linthicum, Md. 21090 Date 2 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Feb. 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion _5 ☐ Other (Specify) 1998 Cedar Hill Cemetery Brooklyn Park, Md. 21. Signature of Funeral Segreto Licensee 22. Neme end Address of Fecility
McCully-Polyniak Funeral Home or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, List only the cause on each line. 237 E. Patapsco Ave. Baltimore, Md. 21225 **Approximate** Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) Atheroscleratio Cardiovascular Disease /Medical Examiner Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or as e consequence of): Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other elanificent conditione contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? 1 Yes 20 No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) To Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) XYes 2□ No 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: Maturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

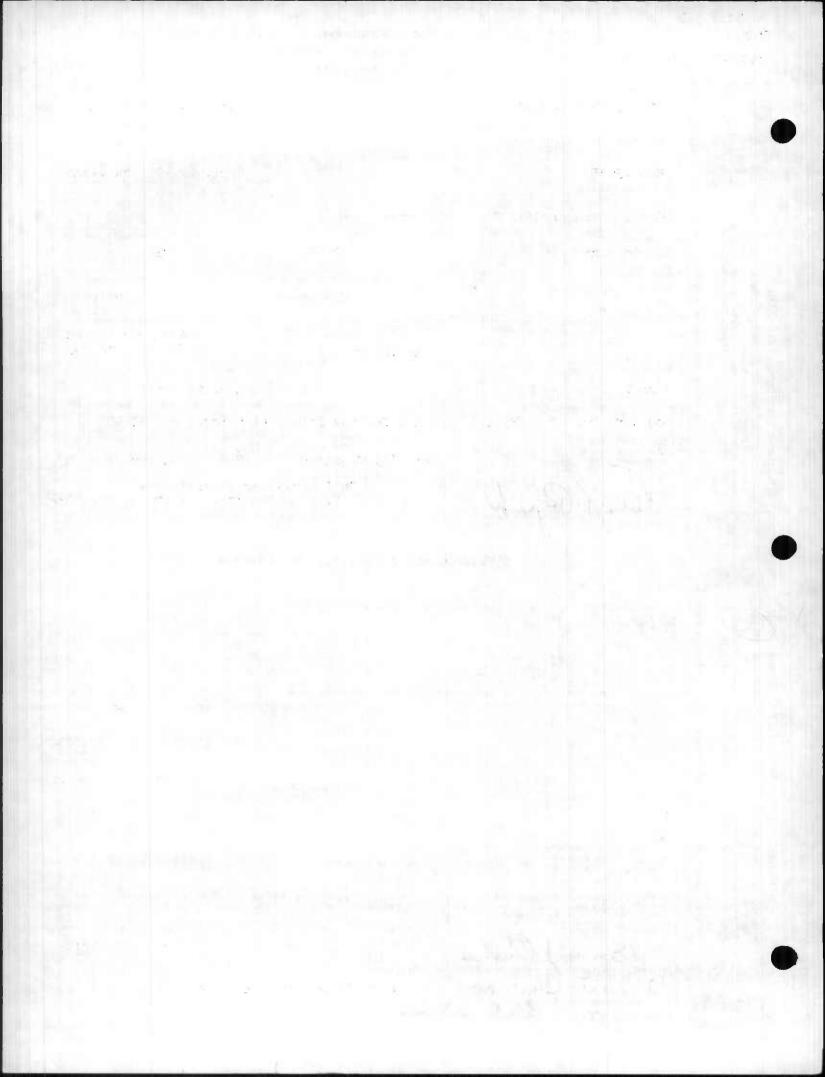
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E JAN. 31, 1998 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar hute

MD.

lennis v

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Eugene Neal Bledsoe 8:45 M Fel 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death St. Agnes Hospital Baltimore Baltimore City 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Dev. Year) March 18,1918 6. Sex 9. Birthplece (Stete or Foreign 1∏M 2□ F Months Days Virginia 224-18-0786 79 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Baltimore County Maryland Catonsville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 11 Paradise Avenue 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ XXX If Yes, Give Yaer or Dates: 1 Never Married 2 Married 1 ☐ Yes a ☐ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown laborer construction 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Corneilius Bledsoe Mary Lunsford 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) Ms. Virginia Collins/sister 4710 Woodland Road, Ellicott City, Maryland 21043 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stata 1 █ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata Good Shepherd Cemetery 5FEB98 Ellicott City, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signutury of Funeral Servica Licansee 22. Name end Address of Fecility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 Part1. Entar tha disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrest shock, or heert fellure. List only one cause on each line. Approximeta Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in deeth) Week Due to (or as e consequenca of) Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"netural", or itams 23a or 28a-f show adical Examiner must be notified at

should be filed within 72 hours effer and Mental Hygiene. marked other than "netural", or ital smetic event, the Medical Examination.

permit. Pages 1 end 2 should be i Depertment of Health and Mental I Important: If item 27 Is marked of any Injury or other traumatic eve

Baltimore, Maryland 21215-0020

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Division of Vital

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Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to Immadiata cause. Enter Underlying Cause (Diseesa or Injury that initieted events resulting in death) Lest

1 Yes 2 No 3 Probably 4 Unknown

exacertation of CHronic obstructive Renal Pailure 26. Plece of Death (Check only one)

24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth

28e. Date of Injury (Month, Dey Year) 5 Pending Investigation

Hospital: 1 npatient 2 ER/Outpetlant 3 DOA 28b. Time of

28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 Tyes 2 No

Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

4 Homicide

3 ☐ Suicide

Be

Medical Certification: To

Director

0

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, data end place, and dua to the ceuse(s) end manner stated.

ACM ES

29b. Signatore and title of certifiar

Marlale

29c. License number

29d. Date signed (Month, Day, Year)

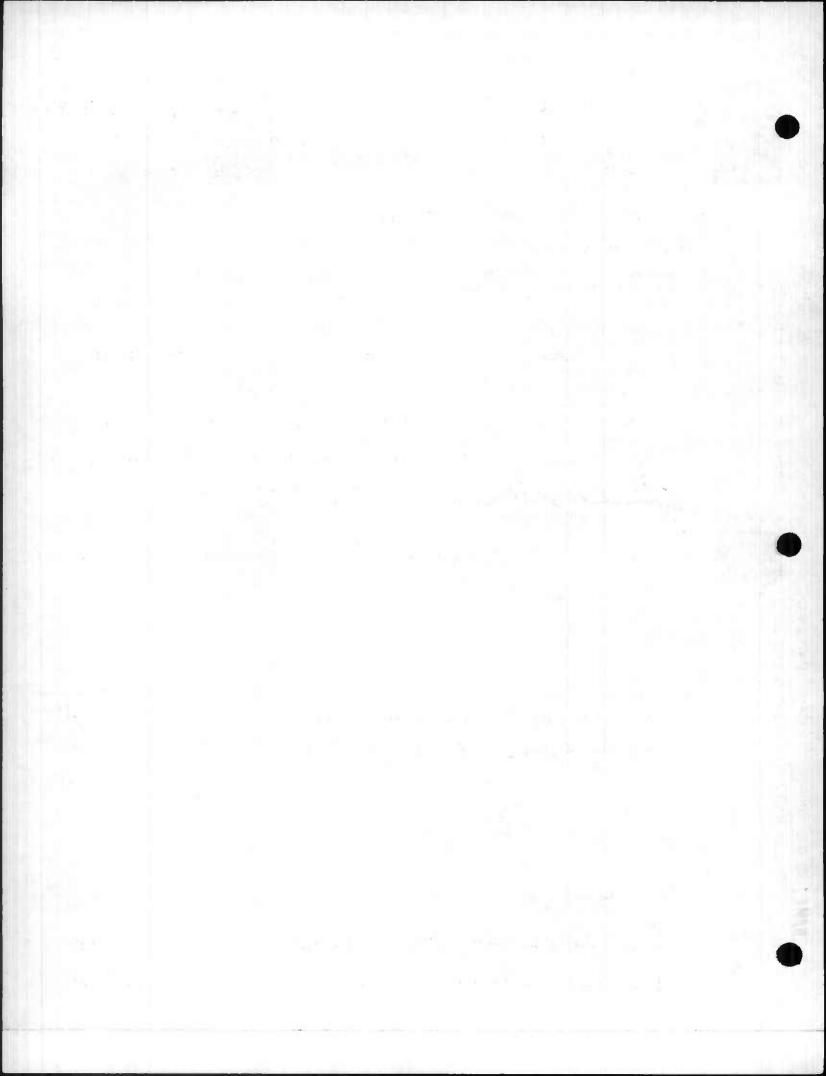
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MUTD MRD CAM LOND ST

6 ☐ Could not be

32. Registrar's Signeture

31. Date filed (Month, Day, Year) Julia Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** BARTHOLOW , SR JAN. 29 1998 12:12 P.M. CT.ARK **EDWARD** ' /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 8505 DEMPSTER COURT APT. C PARKVILLE If Under 24 Hrs. | R BALTIMORE If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Yeer) 6 Sex Birthplace (State or Foreign Country) **Funeral** 12XM 2□ F Months Days Hours Min. Yrs. Director 213-18-3027 78 1/17/20 MARYLAND Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d, Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Exerciper must be notified at 1 ☐ Yes 2 ☑ No Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 Funerai USA 8505 DEMPSTER COURT APT. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 25 Married Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 1 Depertment of Health and Mental Hygiena. Important: If Item 27 is marked other than "n any Injury or other traumatic event. Flementery/Secondary (0-12) College (1-4or 5+) WESTINGHOUSE 10th GRADE SPRAY PAINTER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be ANDREW B. BARTHOLOW SADIE WILLIAMSON 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 8505 DEMPSTER COURT APT. C. BALTIMORE, MD ELIZABETH A. BARTHOLOW Baltimore. Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HIGHVIEW MEM. GAR. 2/2/98 FALLSTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JOHNSON FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one ceuse on each line. TOWSON, MD Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) LUNG CANCER 4 MONTHS Examiner Examiner physician end the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by (1 ☐ Yss 2 ☐ No 3 Probably 4 Unknown HOHF g Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed certificata has 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident or Attendation of the order: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) Mid.

VA MEDICAL CTR, 10 N GREENE

MD

BALTIMORE

Registrar DHMH 16 Rsv 6/95

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

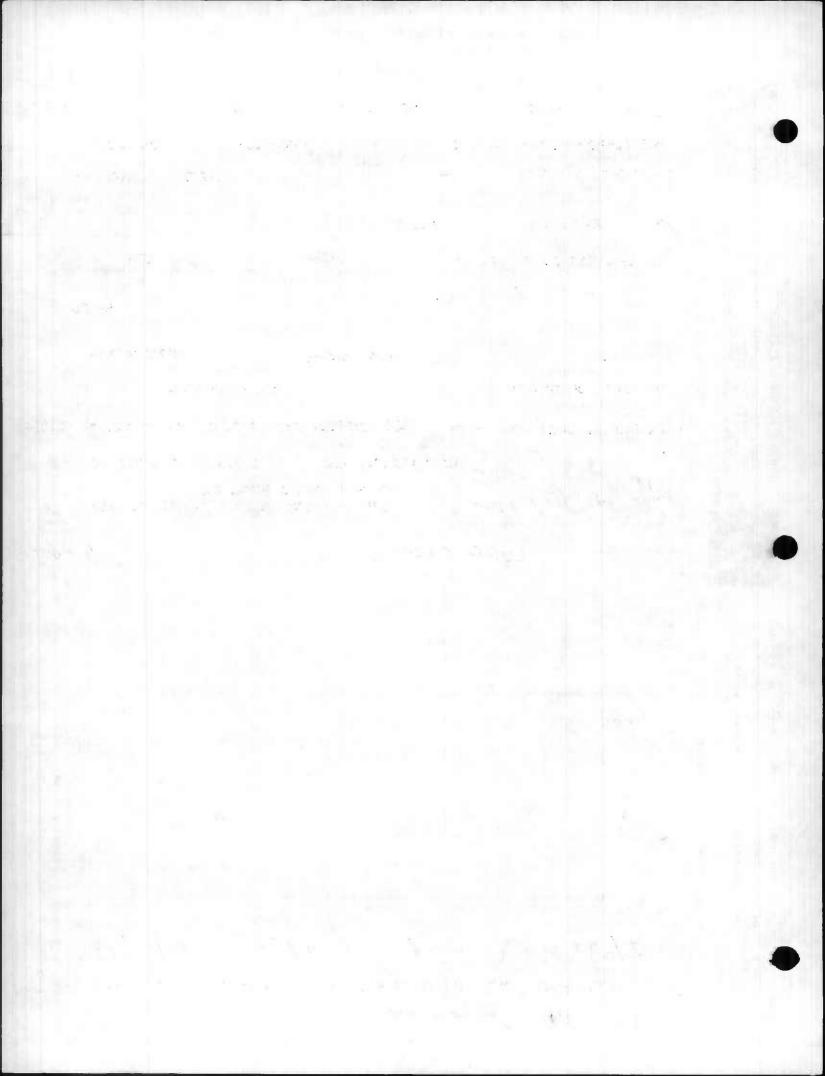
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32. Megistrar's Signature

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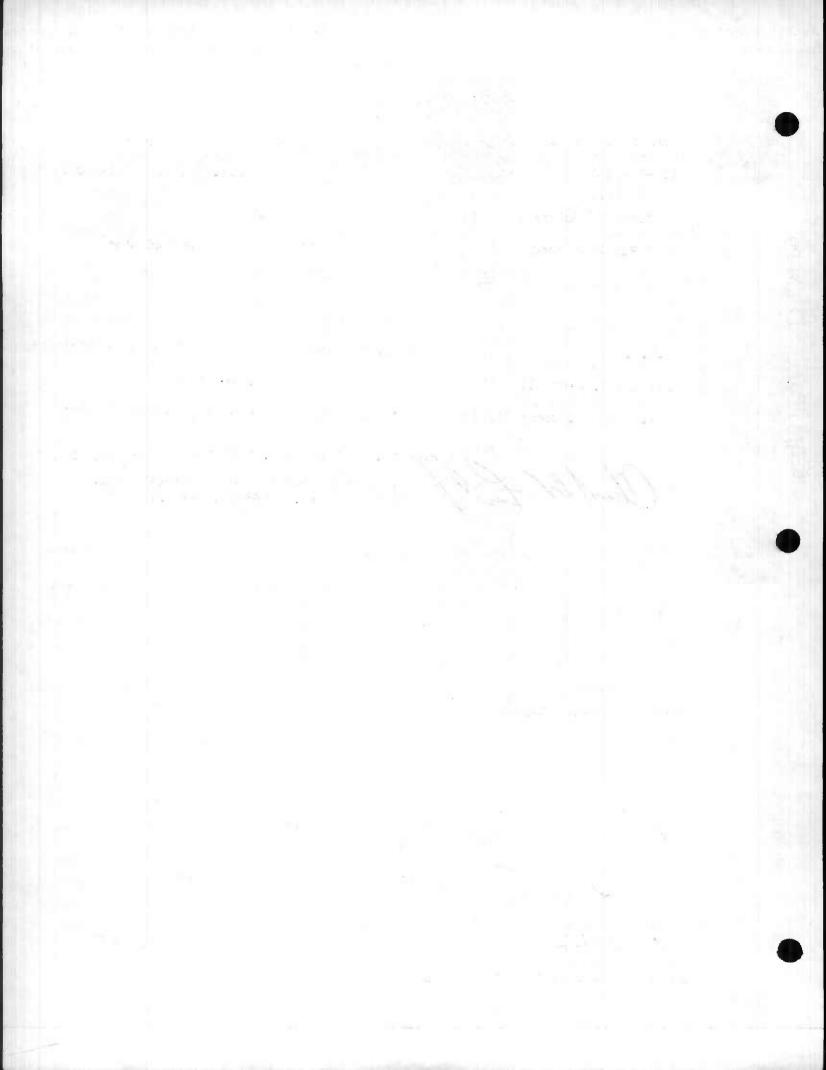
31. Date filed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene 8 0 2 5 7

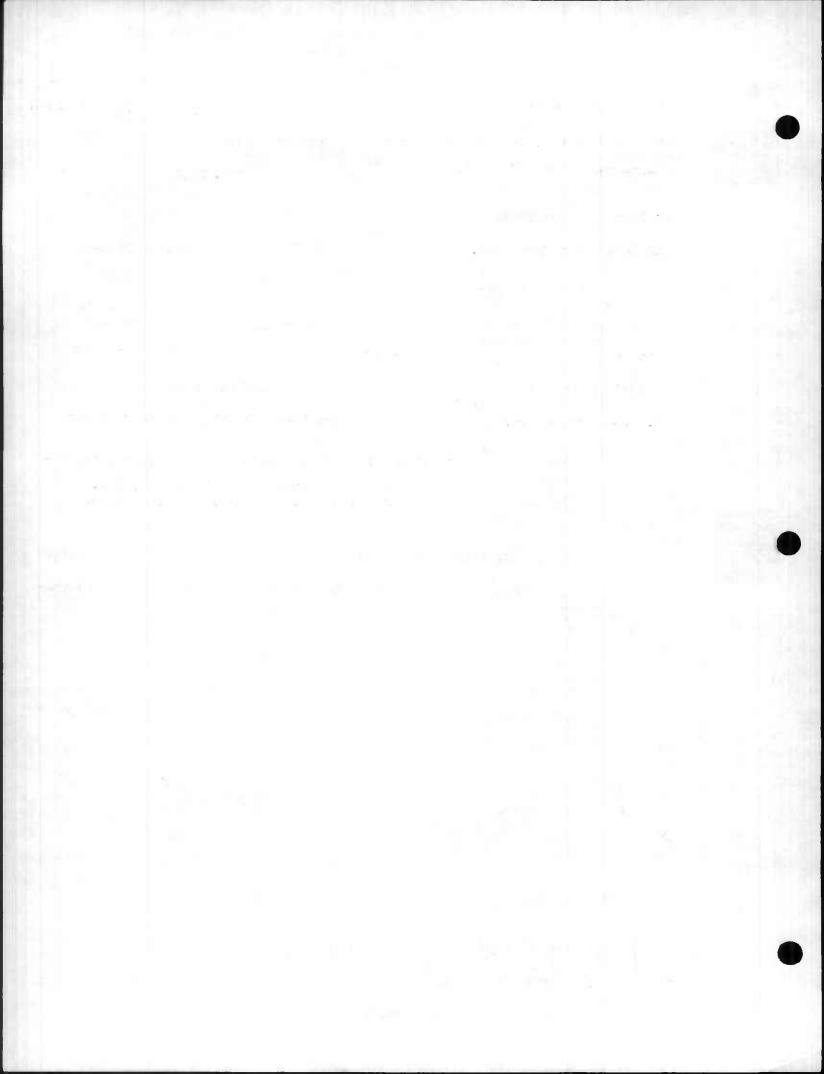
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			1. Decedent's Name (First, Middle, Lest)				77		2. Dete of De	ath	Vaar	3. Time	of Death
	Physic /Medi		Bernard Leroy Campbell							JANUAR	Y 28	1998	03:10) A.M.
	Exami		4a. Facility Name (If not institution, give	street end number	r)		,		4b. City, Town, or L					
			GREATER BALTIMORE	MEDICAL	CENT	ER			TOWSON		BAL	TIMO	RE	
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	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	v. Town or l.	ocation						10d Inside	Clty I Imite
	he Maryl 28a-f sho	Director	Maryland Baltimore Dundalk									10d. Inside City Limit		
RD	23a or 2		106. Street end Number 8017 Kimberly Road 107. Zip Code 21222								10g. Citizen of United			
CRNAR!	within 72 hours efter death with the Maryland ene. than "netural", or items 23a or 28a-f show the Medical Evantine must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2⊠ Marrled 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? If Yes, s			If Yes, sp	Decedent of HispenIc OrIgIn? (Specify is, specify Cuben, Mexican, Puerto Ricar Yes 2 I No Specify:			cify Yes or No- lican, etc.) 14. Race - Black, N Specify:			
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and	ed la b	Be	17. Fether's Name (First, Middle, Last)	011					18. Mother's Nan	. McCaf		ne)		
PBeL Maryland	d 2 should be filed th end Mental Hygi 7 Is marked other traumatic event, I	10	Charles A. Campb 19a. Informant's Name/Relationship (T)			10b Mail	ina Addres	n /Ctron	t end Number or Ru			Ctata 7	n Codol	
	the trace		Mrs. Irene H. Ca			801	L7 Ki	mber	ly Road	Dundalk	, Maryl	and	21222	2
CAM Baltimore,	permit. Pages 1 er Depertment of Heal Important: if item 2 eny injury or other once.		20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Loc 20									Location - City or Town, State Dundalk, MD		
Balt	Dependition Depending Importation on Injury		21. Signature of Fundal Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222											
Fin	Dhusisian		23a. Pert1. Enter the disease, or compl shock, or heart failure. List only or	ications that cause ne cause on each	ed the death								Approxime Interval Be Onset end	etween
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E	he ett	Sic	Part II. Other significant conditions cor	ntributing to death	but not resu	ulting In the u	underlying	ceuse gi	ven in Part I.	23b. Dld	tobacco use co	ontribute 1	to the cause	of death?
, P.O	s that the death ined by the etter e detached for i	by Physiclan/	CHRONIC ROWAL FALURE								1 ☐ Yes 2 ☐ No 3 ☐ Probably 4			Unknown
Division of Vital Records, P.O. Box	or Attending Physician: The law requires that the death certificete be executed strandeth. Director: After this certificete hes been signed by the ettending physician end in by the funeral director, page 2 should be detached for use as the bunel-transit.	Completed t								24e. Was perfo	en eutopsy ermed?	C	ere autopsy vailable prior ompletion of deeth?	rto
Ä	The lav	E O								10	Yes 21 No	1	☐ Yes 2[□No
it a	certificate rector, par	BeC	25. Was case referred to medical						26. Place of Dea	th (Check only	one)			
>	Physician: this certific al director,	To	examiner? 1 Yes 2 No	fospital: 1 Inpat	tient 2	ER/Outpatie	nt 3 🗆 🗅	OA Ot	her: 4 Nursing H	ome 5 Resi	dence 6 🗆 Ott	her (Speci	ify)	
0	ding Phy. h. After thi funeral	:uc	27. Manufer of Death 1 Matural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ey Yeer)	28b. Time o	of	28c. Inju Wo	ry at NA		how Injury occu	rred		
Sio	Attending Property octor: After the funerally	catic	2 ☐ Accident investigation	NI		NA	М		Yes 2□No	N	A			
Dívis	To the Hospital or Attend within 24 hours effer deeth To the Funerel Director: . completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Ir building, e	njury - At ho atc. <i>(Specif</i>)	me, farm, st	reet, facto	ry, office		City or To	Street end Num wn, Stete) V/-	ber or Rur	ral Route Nu	mber,
	To the Hospital within 24 hours of To the Funeral completely filled	edical	29a. Certifier (Check only one)	sician: To the best ner: On the basis and menner s	of examinat	wledge, deat ion end/or In	h occurred vestigatio	et the ti	ime, dete and place opinion, death occur	, and due to the rred at the time,	ceuse(s) and m date and plece,	anner as a	stated. to the ceuse	(s)
	To th To th	Me	29b. Signature and title of certifier				29	c. Licen	se number		29d. Date signe	ed (Month,	Dey, Year)	
			Sevend RN-lan					25			1-26	F-9	8	
	10		30. Name end eddress of person who co	empleted cause of	death (Item	23e) (Type	Print)	LANG	D 212	34				
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	trar's Signa	ture								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Neme (First, Middle, La						2. Date of De Month	Day	Yeer	3. Time of Deat	
Physician /Medical	1	Doris Crowt		3			4b. Clty, Town, or	Januar		1998	4:31 P	
Examiner	r	4a. Facility Name (If not institution, given Johns Hopkins Bo			1 Cente	r	Baltima		4c. County		N/A	
Funeral Director		220-07-9144	Sex 1□ M 2DXF	7. Age (In yrs 76	: last birthday) Yrs.	If Under 1 Ye Months Day		. (Month, Da	th ly, Year) 30,1921		ace (State or For ry) yland	
ahow		Usual Residence of Decedent 10a. State 10b. County	244	10c. C	ity, Town or Lo	cation	Para			10	d. Inside City Lin	
ust be notified at ust Director	200	Maryland Ba	ltimore			10f. Zip Cod		mere	10g. Citizen of	What Count	1 ☐ Yes 2 \(\O\)	
iner state or star a siner must be notified Funeral Director	2	2825 Lodge Farm		pt. 40			21219		United	Stat	es	
by by	2	11. Marifal Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Pivorced	12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	ces? 2 🔯 No e		Was Decedenf of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No rto Rican, etc.)	Specify	ce - America ck, White, e y: Wh		
t, the Medical	napidille	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1	-4or 5+)	(Give	DO NOT use ref	ne during most of wo	16b. Kind of B		ustry		
D 2 0	5	8 Years 17. Father's Name (First, Middle, Last,)		Casti	iter	18. Mother's Na	me (First, Middle,	_	Hospital Maiden Surmame)		
atic ev To B	2	Archibald Daughe	Eli	zabeth	Lentz							
900		19a. Informant's Name/Relationship (_								
Item 27 i		Mrs. Nancy Hoope	er Barre			Watervi sition (Name of		Dundalk,	20c. Location		1222	
y or o		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		State	cemetery, cren	Cemeter	olace)				Maryland	
important: If any injury or once.	-	21. Signature of Funeral Service Licer		Va	22	Name and Ad	dress of Facility			·		
SEES							Funeral Ave. Du					
ysician Medicai aminer		Immediate Cause (Final diseese or condition resulting in death)	a. ca		or as a conseq	wthn jueno of):	ua madau				I Now	
attending physician end for use as the burial-transit	BOIDO	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence or as a consequence		ppyy					
d by the attendin		Part II. Other algnificant conditions of	ontributing to de	ath buf not re	sulting in the ur	nderlying cause	given In Part I.	23b. Dld	tobacco use co	ntribute to	the cause of de	
90 90								1 🗆	Yes 2 No	3 Prob	ably 4 Unkr	
s been s 2 should pleted								24a. Was perio	an eutopsy ormed?	avai	re eutopsy finding ilable prior to apletion of cause eath?	
certificate harector, page								10	Yes 2 XNo	10	Yes 2000	
		25. Was case referred to medical examiner? 1 ☐ Yes 2 → No	Hospital:	patient 2] ER/Outpafien	f 3□ DOA	Othor	ece of Death (Check only one)				
fter the		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date o (Monti	f Injury n, Dey Year)	28b. Time of Injury	28c. Ir	njury et Vork?	lome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how Injury occurred				
Directo I in by t		3 Suicide 6 Could not b 4 Homicide determined	28e. Place	of Injury - Aft g, etc. <i>(Speci</i>	nome, farm, sfre	eet, factory, offic	Ce	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
0 = 6 ()		29a. Certifier (Check only (Ch								anner as sta end due to	ited.	
Funeral letely filled		(Check only one)	one) and manner stated.						20d Data slaved (Marth			
Winin 24 hours and loadi. To the Funeral Director: A completely filled in by the funeral Medical Certificati		one) 2 Medical Exam	and mann			ODe Lies	ense number		29d. Date signe	od (Month, D	N W	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death 30 **Physician** Dominic J. Cammarata, Sr. 1998 11:55 AM January /Medical 4e. Fecility Nema (If not institution, give straaf and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner VAMHCS FORT HOWARD DIVISION FORT HOWARD BALTIMORE If Undar 1 Year Months Days If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 09-11-24 5. Sociel Security Number 8. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
BALTIMORE **Funeral** Hours 1⊠M 2□F Director 219-12-8572 73 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location the Marylar 10d. Insida City Limits MD n/a Baltimore Directo 1 Vas 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? r than "natural", or items 23a or the Medical Examiner must be a 2056 Whistler Ave. 21230 United States Funeral 12. Was Decedant Evar in U.S. Armed Forces? 7 / 43 -1 ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 11. Marital Status Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. DOMINIC J. Baltimore, Maryland 21215-0020 72 hours after 1 ☐ Never Married 2 Married 0 1 ☐ Yes 2 ☑ No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grade completed) 18a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working life. DO NOT usa ratired) filled within Elementery/Secondary (0-12) Collaga (1-4or 5+) 8 Production Inspector Tin Can Production 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) 1 and 2 should be Health and Mental 7 is marked of traumatic ev Charles Cammarata Mary Cascio 2 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code, 2056 Whistler Ave. Baltimore, MD 21230 Concetta A. Cammarata Item 27 I important: If its any injury or oth once. 20b. Placa of Disposition (Nama of 20a. Mathod of Disposition Pages 1 20c. Location - City or Town, Stete Placa of Disposition (Nama of cometery, cramatory or other place)

Vet's Cemetery Burlai 2 ☐ Cramation 3 ☐ Ramoval from State 2/2 Crownsville, MD 4 ☐ Donation 5 ☐ Othar (Specify) a of Funeral Service Licansee 22. Nama end Addrass of Fecility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd.

Lansdowne , MD 21227

23a. Pert1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, Approximately approximately Approximate Intarval Between Onset and Death **Physician** Immadiata Causa (Final disaese or condition rasulting in daeth) /Medical 6 months CANCER, PANCREAS Examiner Due to (or as a consequance of): Examiner certificate be executed Sequentially list conditions, if eny, laading to Immediata causa. Entar Undarlying Cause (Disaasa or injury that initieted evants resulting In daath) Last ettending physician end for use as the burlel-trar Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequance of) signed by the e Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No Division of Vital Records. by 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy performed? completion of causa of daath? page 2 certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminar? director Be 28. Placa of Deeth (Check only ona) Hospitei: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 ☐ Yas 2 ☐No 10 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28b. Tima of 28d. Dascribe how Injury occurred Certification: Attending Naturel Accident 5 Pending investigation deeth. 1 ☐ Yas 2 ☐ No or Attend efter deeth Director: by the 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicida 28e. Placa of Injury - At homa, ferm, straat, factory, offica building, atc. (Specify) 4 Homlcida Hospital 24 hours e 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and menner es stetad.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and manner stated. edicai 29a. Cartifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and titla of cartifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) aur

9600 NORTH POINT ROAD, FT. HOWARD, MD 21052

Registrar

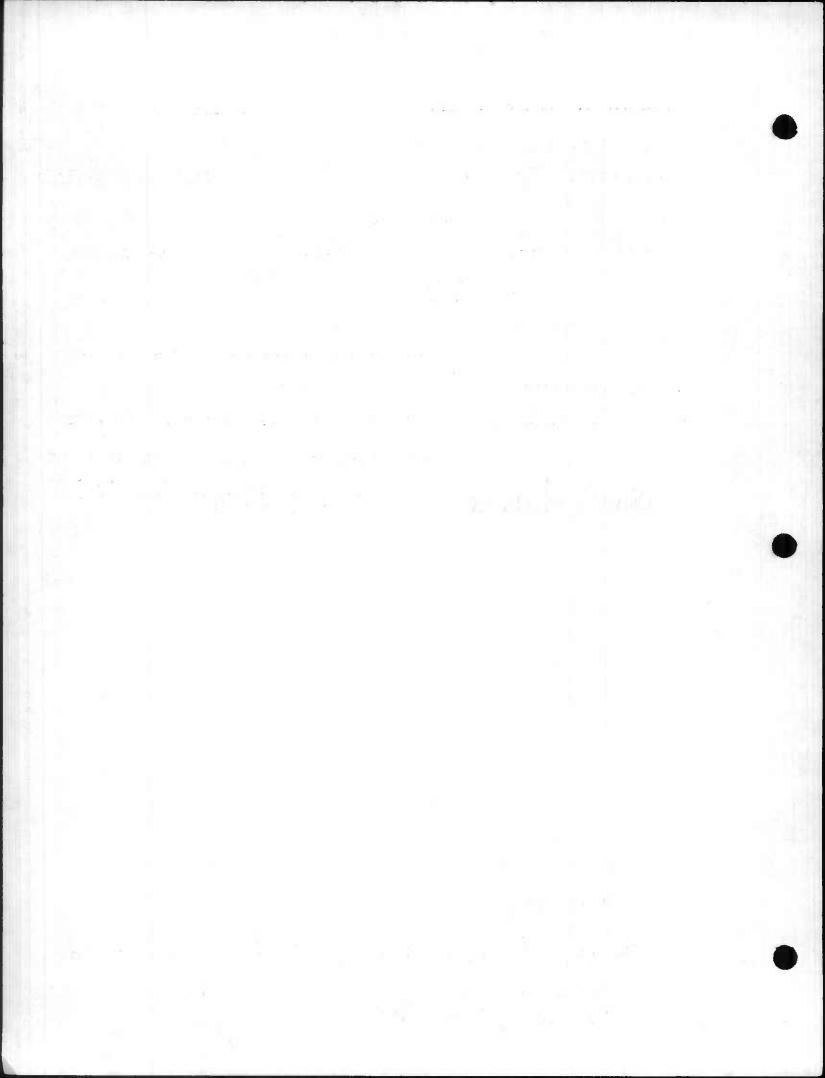
Ma

DR AURORA C. TAN D. 31. Data filad (Month, Day, Year) STER 0 2 1998

30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print)

Partaser

CAMMARATA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nor 1. Decedent's Nama (First, Middla, Last) 3. Time of the 2. Data of Deeth Month 3:38 31,1998 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Nema (If not institution, give streat and number) BALTIMORE HARBOR HOSPITAL CENTER 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 6 Sax 7. Aga (In yrs. last hirthday) Birthplaca (State or Foreign Country) NC 1 M XX Days 212-46-7011 Yrs. Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. insida City Limits n/a Baltimore 1 Tas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21225 5903 Belle Grove Rd. USA 12. Was Decedant Evar In U,S. Armad Forces? 1 ☐ Yas 2 Ā Ā 6 If Yas, Giva Yaar or Detas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2KNo Specify: Black. 3 Nidowed 4 □ Divorcad 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) Housewife 6th Domestic 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Willie Parker Bessie Wilson 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Judy Mercer/granddaughter 5903 Belle Grove Rd. Balto., MD 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, crematory or other placa) Date 20c. Location - City or Town, State 1 Surial 2 Cramation 3 Ramoval from Stata 2/6 King Memorial Park Randallstown, MD 4 ☐ Donation 5 ☐ Other (Spacify) of Funaral Sarvice Licansee 22. Nama and Addrass of Fecility James A. Morton & Sons Funeral Home 23a. Part. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, privately private the disease. Approximate Interval Betw Immediata Causa (Final SEPTIC SHOCK disaasa or condition RESPIRATORY FAILURE 2nd to Due to (or as a consequence of): PNEUMONIA Sequantially list conditions, if any, laading to Immadiate causa. Entar Undarlying Ceusa (Disaasa or injury that initiated avants rasulting in daeth) Last Dua to (or as e consequence of): SMALL BOWEL Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION, DEHYDRATION, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evallabla prior to completion of ceusa of daath? METABOLIC ENCEPHALOPATHY 24a. Wes en autopsy performed? ALZHEIMERS DISEASE 1 Yas 2 No 25. Wes cesa raferred to madicel axaminar?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f shoulded Examiner must be notified at

the Medical

I Hygiene.

. Pages 1 and 2 should be filed w iment of Health and Mental Hygien fant: if item 27 is marked other ti lury or other traumatic event,

permit. Page Department o Important: If i any Injury or

Director

Funeral

þ

Completed

Be

the Maryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

P.O. Records, 2 of Vital certific ##

Division

Physician/Medical by Be Completed 27. Manner of Daath 1 Natural 2 Accident

Examiner

Certification: To 29a, Cartifier

Affar i or Attend after deatl Director: To the Hospital of within 24 hours a To the Funeral D Medical

State Registrar

31. Date filed (Month, Dey, Yaer) EEB 02 1998

1 ☐ Yes 2 No

3 Suicida

29b. Signature

4 Homicide

5 Panding invastigation

6 Could not be datarminad

122. Registrar's Signatura
Aundaea
Aundaea

Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA

28b Time of

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

28a. Data of Injury (Month, Day Yaar)

26. Pleca of Death (Check only ona)

Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify)

28c. Injury at Work? 1 Yas 2 No

28d. Dascribe how Injury occurred

28f. Location (Streat and Number or Russ Routa Number, City or Town, Stete) Certifying Physician: To the bast of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as steted.

Medical Exeminer: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29c. Licansa number

29d. Data signad (Month, Day, Year)

quilland Illa 30. Nama and eddrass of person who completed cause of daath (Item 23a) (Type, Print)

3001 South Hanover St. Balt. MD INO R. ARQUILLAND MD

The arrive

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath JANUARY 20, 1998 VIRGINIA B. CONNELLY 1.45 am 4e. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Daath 4c. County of Death FOX MEADOW ASSISTED LIVING GLENWOOD HOWARD 5. Social Sacurity Number If Under 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Ye April 23 Birthplace (Stata or Foreign Country) Days Months Hours 212-78-3122 1 M 2 F 88 1909 Mississippi Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Maryland Montgomery Silver Spring 10e. Streat end Numbar 10f. Zip Coda 10g. Citizen of What Country? 16701 New Hampshie Avenue 20905 United States 14. Race - American Indian, Black, White, atc. Was Dacedent Ever in U,S. Armad Forcas?

1 Yas 2 No
If Yas, Give
Yaar or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 1 Nevar Marriad 2 Marriad 1 ☐ Yas 2 💢 No Spacify: Specify: White 3 XWidowad 4 ☐ Divorcad 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedent's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Frederick Brown Emma Anderson 19b. Mailing Addrass (Streat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda) 20905 19a. Informant's Nama/Ralationship (Typa, Print) 16701 New Hampshire Avenue, Silver Spring, Maryland ace of Disposition (Nama of Date 20c. Location - City or Town, Stata Marcia C. Kelly/Daughter 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 Domin 5. Other (Specify) Metropolitan Crematory 1/21/98 Alexandria, Virginia 22. Nama and Addrass of Facility Muriel H. Barber Funeral Home Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, 20882 Approximata Interval Batween Onsat and Death 5 days Immadiata Cause (Final disaasa or condition rasulting in death) DNE amonia Dea to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

2

Funeral

Director

ahow

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylas Department of Health and Menial Hygiens. Immortants if frem 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the second profiled in the fired profiled.

Baltimore, Maryland 21215-0020

Iner physician and s the buriel-transit use es for u ate hes been signed page 2 should be de within 24 hours efter death.

To the Funeral Director: After this
completely filled in by the funeral

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Saquantially list conditions, if any, leading to Immediata causa. Enter Undarlying Causa (Disease or Injury	2	or as a consaquanca of	<i>j</i> .				
Causa (Disaasa or injury that initiated avants resulting in daath) Lest	Due to (o	or as a consaquance of)	:				
Part II. Other significant conditions	d. contributing to death but not ras	ulting in the underlying	causa givan in Part I.	23b. Did tobacco use co	entributa to the cause of death?		
dement	ia, Alzher	'mus		1 □ Yes 2 No	3 Probably 4 Unknown		
				24a. Was an autopsy performad?	24b. Wara autopsy findings available prior to completion of cause of death?		
				1□ Yas 2√ No	1 ☐ Yes 2 ☐ No		
25. Was cesa rafarrad to madical exeminar?			26. Place of Da	ath (Check only one)	topsy 24b. Wara autopsy findings available prior to completion of cause of death? 24D No 1 Yes 2 No 6 Other (Spacify)		
1 ☐ Yas 2 No	Hospital: 1 ☐ Inpatiant 2 ☐	ER/Outpatiant 3 D	OA Othar: 4 Nursing	Home 5. Hasidance 6 □Oth	nar (Spacify)		
27. Manner of Daath 1. ■ Natural 5 □ Panding 2 □ Accident invastigatio		28b. Tima of Injury M	28d. Dascribe how Injury occurred				
3 Suicide 6 Could not be datarmined		oma, farm, straat, facto	ry, office	28f. Location (Straat and Numb City or Town, State)	bar or Rural Routa Number,		

and manner stated.

→ Setting Physician: 10 the best of the past
RUMELL

AVE.

29d. Data signed (Month, Day, Yaar)

GAITHERSMURG, Not DOSTS

State Registrar

Medica

30. Name a

29b. Signature and title of certifier

31. Data Med (Month, Day, Year)

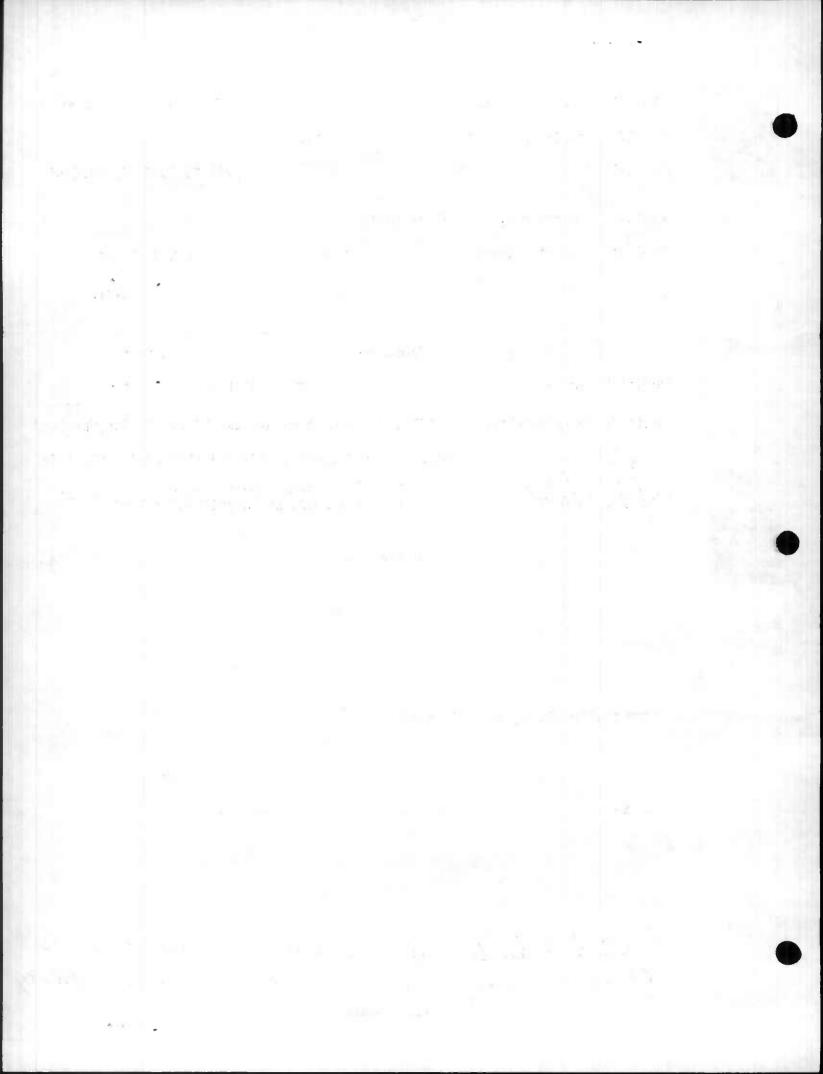
JAN 3 0 1998

ress of parson who completed cause of death (Item 23a) (Typa, Print)

menich

32. Ragistra's Signatura

To the Hospital within 24 hours e



VERA CASE

> Physician /Medical Examiner

Funeral Director

pemit. Pagas 1 and 2 should be filed within 72 hours efter death with the Manyler Department of Health and Mentel Hygiane. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

ate has been signed by the ettanding physician and page 2 should be deteched for use as the bunel-trensit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

1. Decedant's Nama (First, Middle	a I get)		Cer	uncai	le oi	Death		2. Data of Dea	Reg. No.	2 Time	of Death
Vera Ilse Ca	se							JANUARY	26, 19	998 9:30	
4a Facility Nama (If not institution 1120 ST.MICHAELS		umber)				4b. City, To MOUNT		ocation of Death RY		y of Death RD COUNTY	
5. Social Sacurity Number 216–23–4321	6. Sex 1 ☐ M 2 ☑ F	7. Aga (In yrs. 31	Ven	If Unda Months	r 1 Yaar Days	If Undar Hours	24 Hrs. Min.	8. Data of Birth (Month, Day Mar. 4		9. Birthplace (State Country) Germ	
Usual Rasidance of Dacedant 10a. Stata 10b. County			ity, Town or Lo							10d. Insida	
MD Howa 10e. Street and Number		N	Mount A		p Coda				10g. Citizen of	1 ☐ Ya What Country?	as 2 No
1120 St. Mich					2177				Germ	*	
11. Marital Status 1 Nevar Married 2 Marr 3 Widowed 4 Divorced	ried Armed F	2₩ No		Vas Dece Yas, spe		dispanic Ori an, Maxicar Specify:		pecify Yas or No- Picen, atc.)	14. Rai Bla Specif	ce - Amaricen Indian, ack, Whita, atc. by: White	
15. Decedan (Spacify only highas Elementary/Secondary (0-12)		(1-4or 5+)	16a. Deced (Giva lifa. L	ent's Usu kind of wo	ork dona	during mos	t of worl	king	16b. Kind of B	Businass/Industry	
12 17. Fathar's Nama (First, Middla, Max Walter Re	Last)		Veter	inary	y Te	18. Motha	ar's Nam	na (First, Middla,	Malden Sumai	ary Hospit	tal
19a. Informant's Name/Ralations	hip (Typa, Print)					and Numb	er or Ru	ral Routa Numbe	or, City or Town	ı, Stata, Zip Code)	
Dr. David Tayma	n (Emplo	-				ay, E	1	ott City			
20a. Mathod of Disposition 1 ☐ Burial 2 🏋 Cremation 4 ☐ Donation 5 ☐ Othar (S		State	Place of Dispos camatery, cran ltimore	natory or o	othar pla		1	an ^{Data} .30, 199		- City or Town, Stata el, MD	
21. Signatura of Funaral Sarvice	Licensaa	1	W.	itzke	e Fu		Hom	es, Inc			
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O.C.M.E.

JANUARY 27, 1998

111 Penn Street, Baltimore, Maryland 21201

Division of Vital Rec

To the Hospital or Attending Physician: The law
within 24 hours efter death.

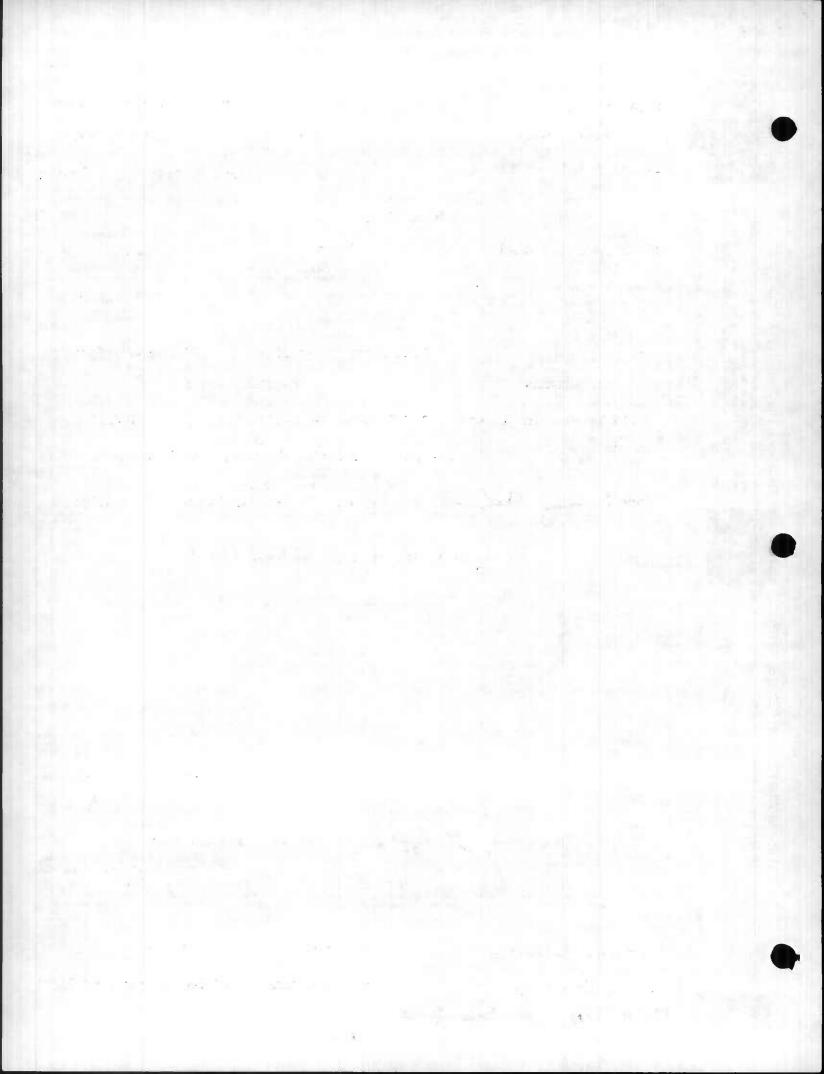
To the Funeral Director: After this cartificate has t
completely filled in by the funeral director, page 2 s

State 31. Registrar

Dennis J. Chute, mo 31. Data filed (Month, Day, Year) 32. Reg FEB 0 2 1998 Julian Land

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Januar /Medical 4a. Fecility Nema (If not institution, giva street and number 4b. City, Town, or Location of Daeth 4c. County of Death **Examiner** akylan saltimore 5. Social Security Number 7. Age (in yrs. last birthday) If Under 1 If Under 24 Hrs. Birthplace (State or Foraign Country) **Funeral** 64Yrs. 1 M 2 K Months Days 1/35 September/6,1933 Director Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Insida City Limits 1 Ves 2 No Director laryland more 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? permit. Peges 1 end 2 should be filed within 72 hours after deeth with Department of Health and Mental Hygiene. In procrant: If Item 27 is marked other than 'natural', or Items 23a or any Injury or other traumatic event. 2 5 212 Funeral ngton Ad. H 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Maritel Status 13. Was Decedant of Hispenic Origin? (Specify Yes or No If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Rece - Amaricen Indien, Black, Whita, atc. 1 Navar Marriad 2 Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Black Specify þ ff Yas, Give Yaar or Dates: 3 ₩idowed 4 Divorced Completed 16a. Decedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12+4 HOUSE Keeping 18. Mothar's Name (First, Middla, Maidan Surnama) 17. Fethar's Nama (First, Middla, Last) Be Smith 2 John Henry Georgeanna 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet end Numbar or Rural Route Number, City or Town, State, Zip Coda) finare, Ministra Brother loudington Kood, Bo 20b. Place of Disposition (Name of cematary, crematory or other plece) 20a. Method of Disposition Date February 1 ☐ Burial 2 ☐ Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funaral Sarvice Licansas 22. Name and Address of Facility IPour Bouglass Funeral Service Street, Baltimore, Meryland Tomplications that caused tha death. Do not enter the mode of dying, such es cardiac or respiretory errest, only one ceuse on each line. 23a. Part1. Entar tha disees shock, or haart feilura. Approximata Onset and Death **Physician** /Medicai Immediata Causa (Finel disaasa or condition rasulting in daeth) Examiner Examiner isease Hospital or Attending Physician: The lew requires thet the death certificate be executed Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last pue Dua to (er es e consaguance of) the buriel-trer P.O. Box 68760. Physician/Medical Due to (or as a consaquence of) 80 ettending | ed by the e Part II. Other significant conditions contributing to death but not rasulting in the undarlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ page 2 should b Completed 24b. Were eutopsy findings eveileble prior to complation of ceusa of deeth? 24e. Was an autopsy performed? 2 No certificate 1 Yas 2 No director, Be 25. Was cesa rafarred to medicel 26. Piace of Death (Check only one) exeminer? Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No Certification: To Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? After 1 Natural 5 Panding invastigation deeth. 1 ☐ Yas 2 ☐ No 2 Accident birector: /d in by the f 6 Could not be datermined 3 Suicida 28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Division of Vital To the Hospital
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> State Registrar

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31. Data filad (Month, Day, Year) FEB 0 2 1998

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29b. Signeture and title of petitic

29a. Cartifian

30. Nema and address of person who complated ceuse of death (Itam 23a) (Type, Print)

32. Registrar's Signatura

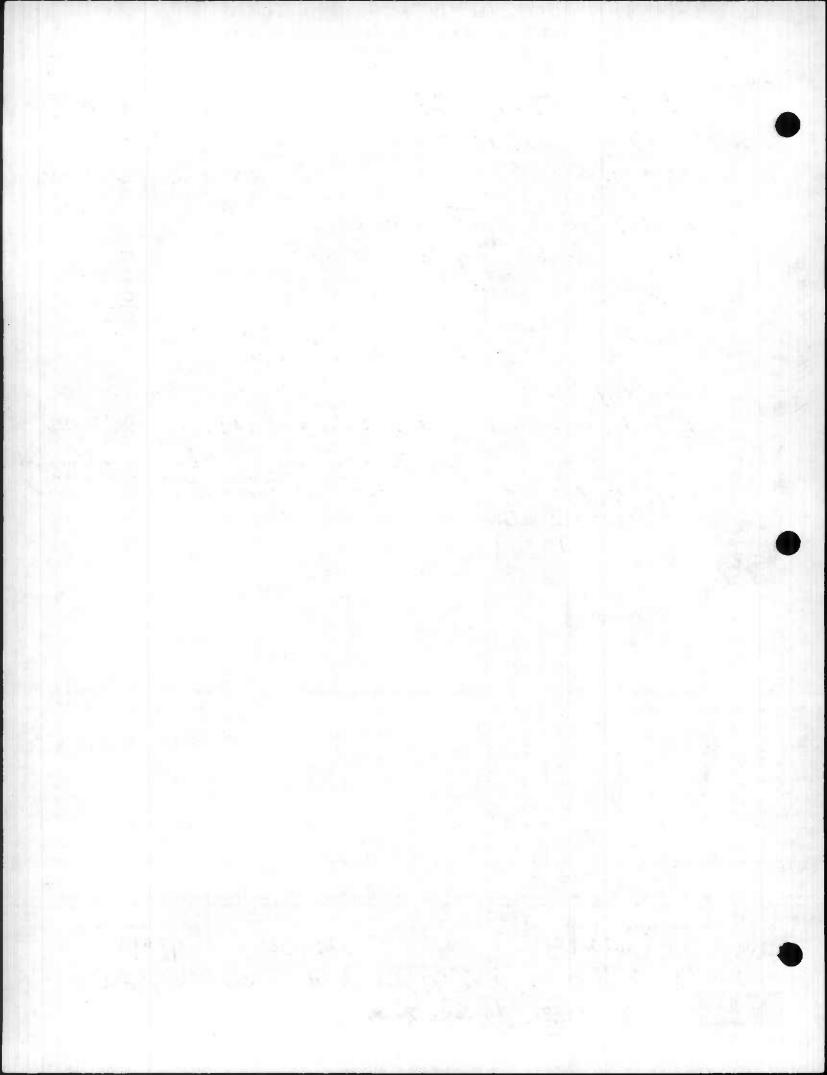
Certifying Physician: To the bast of my knowladga, daath occurred at tha time, dete end place, and dua to the causa(s) and manner as steted.

| Medical Examinar: On the bast of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and mennar stated.

29c. Licansa number

land General

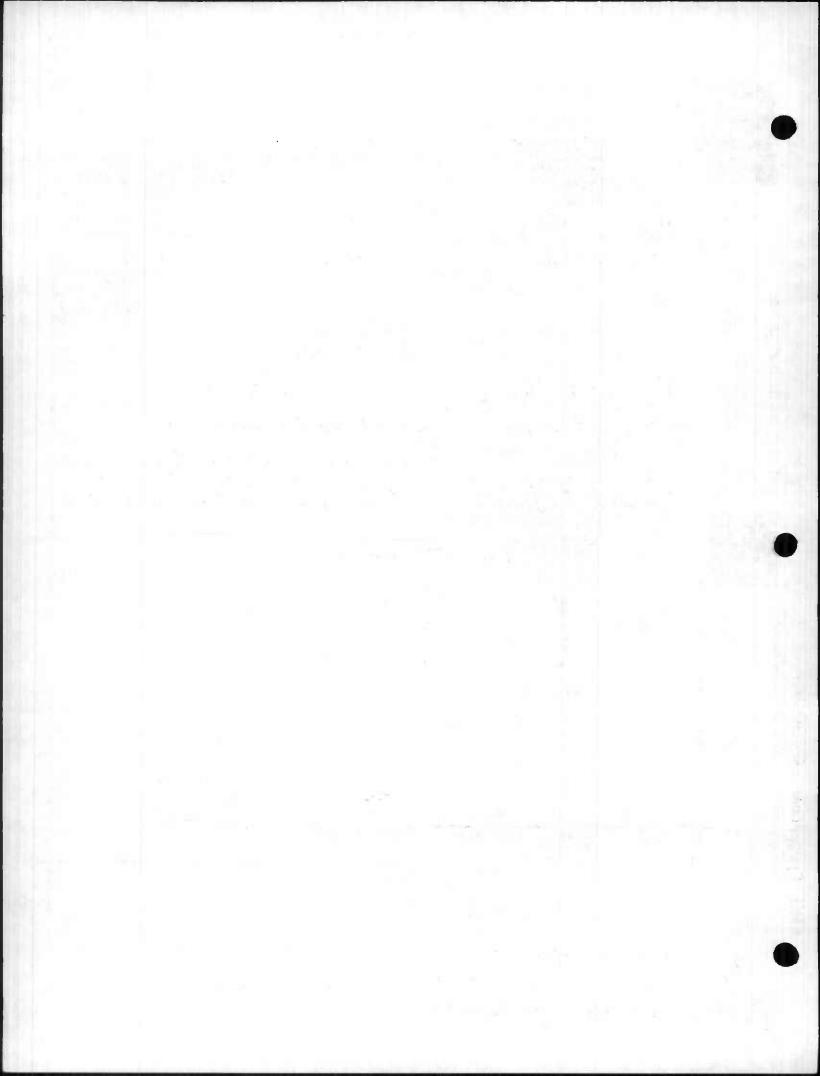
29d. Date signed (Month, Day, Year) 28



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day 29 **Physician** (1550 JAN Cuaene /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/a AGNES Baltimore HUSK If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. lest birthday) **Funeral** 228-05-505 10 M 20 F Months Days 8 Yrs. Director Usual Rasidence of Decedani the Maryland 10a Stata 10b. County 10c. City, Town of Location 10d. Insida City Limits ral', or items 23a or 28a-f shov Examiner must be notified at 1 Tas 2 No Director attimore 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 604 21216 15a 0 Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 ∰ es 2 □ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, White, atc. Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status filed within 72 hours efter 1 Nevar Marriad 2 Married afro Baltimore, Maryland 21215-0020 "natural", or 1 Yas 2 1 No Specify: Completed by 3 Widowed 4 □ Divorced american th end Mental Hygiene.
7 Ia marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elemantary/Sacoadary (0-12) College (1-4or 5+) Worker slee 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be sent of Health end Mental Salah sober a Draylor 19a. Informant's Name/Ralationship (Type, Print) (Son) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Depertment of Health er important: If Item 27 la any injury or other trau Battimore, Md Mr. Eugene R. Drayton 20b. Place of Disposition (Nama of cematary, cramatory or other) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State saltimore, MD. 4 □ Donation 5 □ Othar (Spacify) 21. Signatura of Funeral Service Licensas e. Md. 21216 tuneral 23a art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Betwaen Onset and Death **Physician** /Medical Immadiate Causa (Final disease or condition rasulting in daath) Examiner Examiner bunal-trensit Sequantially list conditions, if any, laading to Immadiate causa. Entar Undarlying Cause (Disaase or Injury that Initiated avants resulting in daath) Last Dua to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequanca of). ed by the attending detached for use es Mellitus Diahele Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 19 Yes 2 No 3 Probably 4 Unknown signed t þ 24b. Wara autopsy findings availabla prior to complation of causa of daath? Completed 24a. Was an autopsy performed? page 2 s certificate 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital DRAYTON or Attanding Physician: director, Be 25. Was casa referred to medical axaminar? 26. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yas 2 No 1⊠Inpatiant 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral Manner of Death 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Panding invastigation Injury 1 Natural 1 ☐ Yas 2 ☐ No after death. 2 Accidant Director 6 ☐ Could not be datarmined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 5 4 Homicida hours a 24 hours 29a. Cartifier 11 Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and dua to tha causa(s) and mannar as stated. Medicai To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Date signed (Month, Dey, Yeer) 11709 M.D. 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) ANTHONY MICKELSON 13 STAGNES HOSP 33 Registrar's Signature 202 31. Data filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar



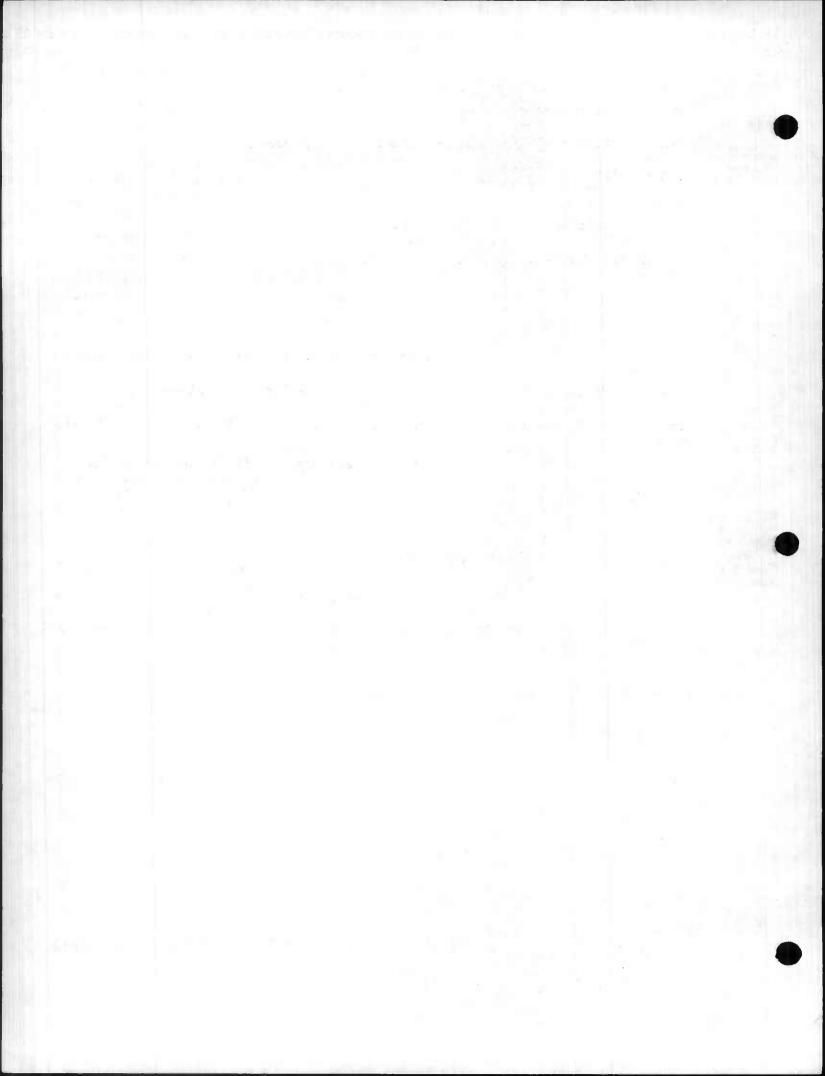
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Nama (First, Middla, I	ast)	U	ertificate or		2. Date of Dee	Reg. No.	, 06.	3. Time of Death		
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Funeral Director		5. Social Security Number 231-16-2684 Usual Rasidance of Dacedant	Sax 1 2 M 2 □ F 7. Age (In yr. 7.5	s. last birthda Yrs.	Months Day:	s Hours Min.	8. Data of Birth (Month, Day Novembe	Yaar) 21,	9. Birthplace Country) 1922	a (Stata or Foreign Virginia		
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	e	7908 Wise Avenue	12. Was Dacedent Ever in	U.S. 13		L222 Hispanic Origin? (Spec	oify Yes or No-	United 14. Red	STATES e - American I	-		
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n 27.1		Nelson Gardner	/ Nephew	433	Poplar I	Leaf Dr. Ed	gewood	Maryl	and 2	1037		
, o		20a. Method of Disposition 1		. Pleca of Disp cematary, cr	position (Nama of amatory or other pl	ace)	Dete	20c. Location	- City or Town,	Steta		
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4		AURORA TAN, M.D.			KUAD, FOF	CT HOWARD,	MD 2105	2				
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State of Maryland / Department of Health and Mental Hygiene []

02580 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month 9:05 PM Margaret W. Girdosky 29, 1998 Jan. /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner St. Elizabeth Rehab and Nursing Center **Baltimore** If Under 1 Yeer If Under 24 Hrs.
Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthpleca (State or Foreign Country) **Funeral** 1 □ M 2 1 F Director 215-07-8266 87 Jan. 3, 1911 Maryland Usual Residence of Decedent with the Maryland 10a Steta 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Haalih end Mental Hygiena. Important: If them 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Example man to nother traumatic event, the Medical Example man to have traumatic event, the Medical Example. 10d. Inside City Limits Director 1 ☐ Yas 2 No MD Baltimore Baltimore 10e. Street end Number 10f, Zip Code 10g, Citizen of What Country? Caton 715 Maiden Choice Ln Apt 301 Ridge United States Funeral 21228 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedant Ever in U,S. Armed Forces? 14. Rece - American Indien, Black, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Datas: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: by 3₺ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 communications supervisor state department 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) James J. Wolinski Lillian Wojciechowski 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 21042 Diane J. Hoffman - niece 10307 Pine Ridge Drive, Ellicott City, MD 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Holy Rosary Cemetery 2/7/98 Baltimore, MD 21. Signetyre of Funaral Service Licensee 22. Name end Address of Fecility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, MD Baltimore,
23a. Pertl. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each lina. Approximete Intervel Between Onsat and Death **Physician** /Medical immediete Causa (Final - adens Cencinana disease or condition rasulting in daeth) 2 years Examiner Due to (or es e consequance of): Examiner ician and buriel-transit One week Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disaese or injury that initieted avents resulting in death) Lest Due to (or es e consaquence of): physician sthe buriel Box 68760, Aspiration One week Physician/Medical Due to (or es e consequence of): USB as attending 50 signed by the at d be dateched for Pert tt. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Records. P.O. 23b. Dtd tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy findings available prior to 24e. Was en eutopsy performed? Completed peen completion of causa of daeth? has paga 2 cartificata 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Daath (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this funaral 27. Menner of Death Certification: 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred i or Attending Fafter death. After 1 Natural 5 Pending invastigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Streat end Number or Rural Route Number, City or Town, Steta) 28a. Place of tnjury - At home, farm, straet, factory, office building, atc. (Spacify) 4 Homicide e Hospital of 24 hours a 15 Certifying Physicien: To the best of my knowledge, death occurred et the time, deta and place, and due to the causa(s) and mannar as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, data end place, end due to the causa(s) end mannar stated. 29a. Cartifier Medicai To the Hosp within 24 ho To the Fune completely f 29b. Signature end little of certifier 29c. Licansa number 29d. Deta signad (Month, Dey, Year) 50607 1998 30 30. Nama end add ress of parson who completed ceuse of deeth (item 23a) (Type, Print) Maiden Choice lane Jamil 32. Register's Signature 31. Dete filed (Month, Day, Yeer) State FEB 0 Registrar



State of Maryland / Department of Health and Mental Hygiene 02581 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:28 Robert HARRISON 20 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Tokoma Pk. Montgomery 7. Age (In yrs. lest birthday) If Under 1 Year if Under 24 Hrs Birthplace (State or Foreign Country)
 Md 6. Sex 8. Date of Birth (Month, Dey, Year) 05-26-55 **Funeral** Days Hours 10M 20F Months 217-66-4199 42 Director Usuai Residence of Decedent the Maryland 10e State 10b. County ii Hygiene. other than "natural", or items 23a or 28a-f ehow vent, the Medical Examinar must be notified at 10c. City. Town or Location 10d. Inside City Limits Md. Howard Ellicott City 1 YesX2 No Director 10e Streef and Number 10f. Zip Code 10g. Citizen of What Country? with 8868-B Town & Country Blvd. 21043 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 21 No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Labor T.S.I. 11th Grade NA traumatic event, permit. Pages 1 and 2 should be file Department of Health end Mentel Hy important: if item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Wilbur Harrison Margaret McCain 2 19a. informanf's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) $\,{
m M\,d}\,$. 8868 B. Town & Country Blvd. Ellicott City, Shirlev McKnight 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State King Mem. PK. Cem. 02-02-98 Randallstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Enter the theese, or complications thet caused the death. Do not enter the mode of dying, such as cardlac or respiretory errest, or heart fawure. List only one ceuse on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel in faction my o cardial 30 mm disease or condition resulting in death) Examiner physician end s the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760 certificate be Physician/Medical Due to (or es e consequence of): 98 use signed by the ette Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? should 24a. Wes en eutopsy performed? Completed pege 2 has 1 □ Yes 2 No 1 Yes 2 No this certificate Division of Vital inding Physician: 25. Was case referred to medical Be 28. Plece of Deeth (Check only one) exeminer? Hospital: 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 funerai 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 Naturei 5 Pending 1 Yes 2 No aath investigation 2 Accident 6 Could nof be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and fittle of certifier 29c. License number 0 70 D08546 26 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 8218 WISOUSIN Taubou Betwooda Johns DUR 31. Dete Hed (Month Day, Year) State Registrar

and it was a most of the second

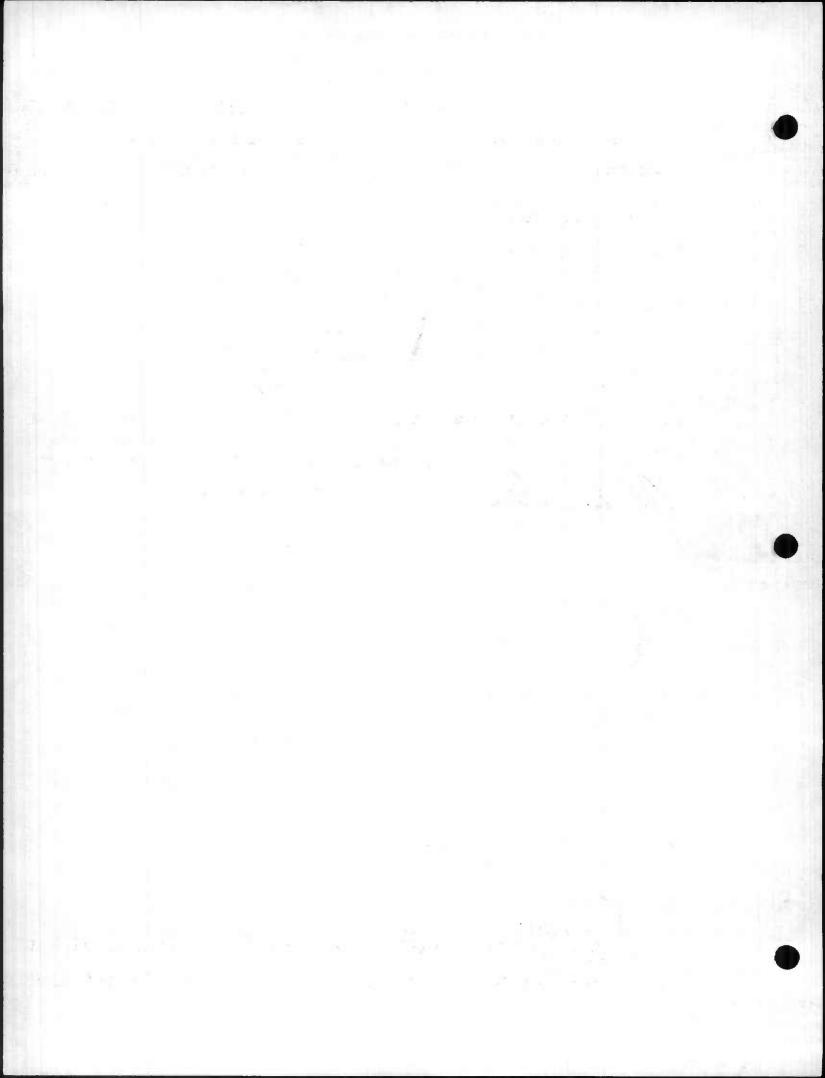
State of Maryland / Department of Health and Mental Hygiene

02582 Certificate of Death 1. Dacedant's Name (First, Middla, Last) 2. Data of Deeth 3. Time of Death **Physician** JANUARY Richard McFern Hemphill 8:15A /Medical 4e. Fecility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 3216 West Springs Drive Ellicott City Howard County | H Undar 1 Year | If Under 24 Hrs. | B. Dete of Birth | Months | Deys | Hours | Min. | May 1 Gay 1 Gay 1 9. Birthpiace (State or Foreign West') Virginia 5. Social Security Number 7. Aga (In yrs. last birthdey) **Funeral** 10 M 20 F 235-42-3078 66 Yrs Director Usual Rasidance of Decedant death with the Maryland 10c. City, Town or Location 10e. Stete 10b. County 10d. Insida City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Howard County Ellicott City 1 ☐ Yas 2 TO No Directo 10f. Zip Code 21043 10e. Street end Number 10g. Citizen of What Country? 3216 West Springs Drive USA Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Biack, Whita, atc. 11. Marital Status permit. Pagas 1 and 2 should be filed within 72 hours aftar Department of Haalth and Mental Hyglena. Important: If item 27 is marked other than "natural", or itel sny injury or other traumatic event, the Medical Examinat 1 ☐ Yas XX No If Yes, Give Year or Datas: 1 Navar Married 20 Married Saltimore, Maryland 21215-0020 1□Yes 2□No þ Specify: white 3 Widowed 4 Divorcad Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5+ self employed dentist 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Surname) Evelyn Roberts Ralph Hemphill 10 19e. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Ms. Gladys A. Hemphill/spouse 3216 West Springs Drive, Ellicott City, MD 21043 20b. Placa of Disposition (Nama of cemetery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata ₱CXBuriai 2 ☐ Cremetion 3 ☐ Removel from Stata Crestlawn Memorial Gdn. 30JAN98 Marriottsville, MD 4 Donation 5 Othar (Specify) 21. Signature of Funeral Service Licenses 22. Nema and Addrass of Facility Slack Funeral Home, P.A. Ellicott City, Maryland 21043 M00535 or complications that caused the deeth. Do not anter tha moda of dying, such as cardiac or raspiratory errast, Approximata Intervel Betw Onset end Deeth **Physician** mmediete Ceuse (Finel disaasa or condition rasulting in deeth) CDRUNARY HEART DISEASE /Medical Examiner Dua to (or as a consaguance of) Examiner Sequantially list conditions, if any, laading to immadieta causa. Enter Underlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last and Dua to (or es e consequance of) physician a s the burish Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): attending process Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the detached 23b. Did tobacco use contribute to the cause of death? signed by i VIABRIEN MEWITYS 1 Yee 2 No 3 Probably 4 Unknown ð ATRIM EIBRILL ATTON 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed has page 2 20 No 1 Yes 2 No certificate 1 TYas Attending Physician: 25. Wes case ratarred to medical exeminar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 10 1 Yes 2 No ä unaral 28a. Data of Injury (Month, Day Year) Certification: 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Affar 5 Panding Invastigation Natural 1 ☐ Yas 2 ☐ No 2 Accidant after death Director: 6 Could not be 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital o within 24 hours at To the Funeral Di completely illed in Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end piece, and due to the causa(s) end manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) Medical 29a. Cartifian 29d. Date signed (Month, Dey, Year) 29b. Signature and JANUARY 28, 1998 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 950 OLD ANAPOW RD RULLT UTY MO 21042 30 MOURER DOUT 31. Dete filed (Month, Day, Year) 32. Registrer's Signetura State Fulia Davidson-Randoll

DHMH 16 Rev 6/95

Registrar



HANSON

10.1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ?

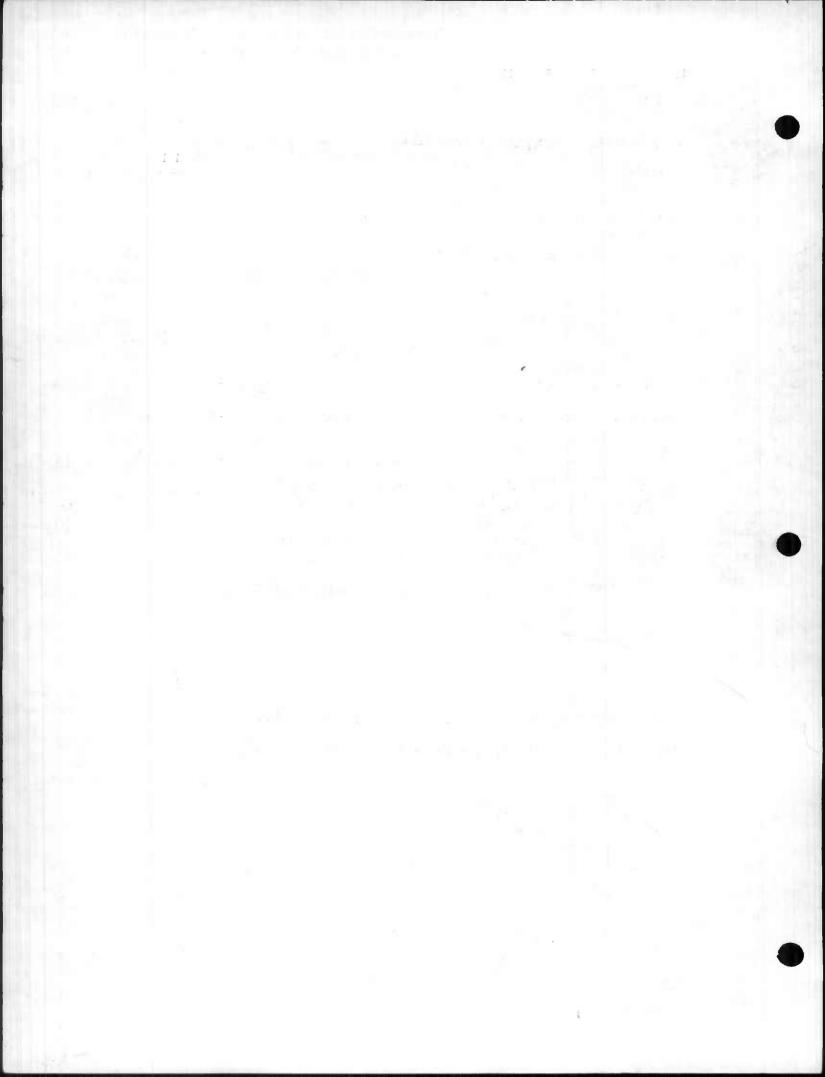
02584 Certificate of Death Item: 8, per F.H. G-756 2/11/98 reb 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey 8, 1998

4b. City, Town, or Location of Deeth 4c. County of Death **Physician** LOLA MAE HART 220 AM /Medical 4e. Fecility Neme (If not institution, give street end number **Examiner** Bouthmore
H Under 1 Year | H Under 24 Hrs. | 8. p maryland GENERAL 5. Social Security Number 8. Date of Birth 1910 (Month, Dey, Year) 09/08/1019 9. Birthplece (Stete or Foreign Country) Virginia 7. Age (in yrs. last birthday) **Funeral** Months Deys Hours 1□ M 25 F 214-12-4481 87 Yrs. Director Usuei Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiena. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinet must be notified at MD N/A BALTIMORE 1 No 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? # 503 301 McMECHEN STREET, 21217 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry WhitestoneBaptist College (1-4or 5+) Elementary/Secondary (0-12) Secretary Church 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Lamb Richardson Mary Bibbins 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a: If Itam 27 is Catherine Arrington 3126 Lugine Avenue, Balto., MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 2/2/98 Date 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of important: If any Injury or National Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) Laurel, Maryland 22. Name end Address of Fecility
LEROY O. DYETT & SON FUNERAL HOME, P.A. 21. Signatura of Funerel Service Lice complications that call the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on earl line. Approximete Intervel Between Onset end Death Acute myocardial Infarct (AREA of Septal Pallor) **Physician** Several /Medicai Immediate Ceuse (Finel hours diseese or condition resulting in death) Examiner Examiner Cardiovascular Rteriosclerotic that the death certificate be asscuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting In deeth) Lest and the bunial-tran Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequença of): as P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t Carotid Endacter ectomes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Be Completed by eteriolar Neph Roscleruis 24e. Wes an autopsy performed? 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 1 Yes 2 No 1 Nes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Mannel of Deeth Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 WNaturel thours after death.

unerel Director: Aft
tely filled in by the fur 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aff To the Funerel Di complately filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner stated. Medical 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of death (Item 230) (Type, Print)
Garth Samuels, M.D. Go Maryland General Hespital

State Registrar 31. Date filed (Month, Day, Year) FEB 02 1998 32. Registrer's Signature



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. F	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MODDIANT is team 20 is marked or team 22 shows any interest trainmatte event the medical eventines must be notified at once
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TO BE

								98	05200
	1 - FOR STATE REGISTRAR	STATE OF MARYL			OF HEALTH AND		HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	EDITH.	HEN	1Df	erson	2. DATE OF MONTH	PROZE	3-9	3. TIME OF DEATH 7.25
	4. SOCIAL SECURITY NUMBER 217 - 14-564	1 - M 2 M F 9	n yrs. lest birthdey) 2 YRS.	MONTHS	DAYS HOURS MIN.	(Month, E			BIRTHPLACE (State or Foreign Country) VIRGINIA
TOR	9a. FACILITY NAME (If not institution, give a CHENESES ELDER (RESIDENCE OF DECEDENT	CARE, PERRIG	pkwy.		arkville	DEATH			Y OF DEATH
DIRECTOR	10a. STATE 10b. COUNTY	timore		TY, TOWN O	r LOCATION Ville				10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	1801 Wentwort				101. ZIP COOE 2123	34		10g. CITIZE	U.S.A.
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	H	VAS DECENDENT OF HISP Yes, specify Cuban, Max YES 21 NO Spe	Ican, Puerto Ric		or No- 14	s. RACE — American Indian, Black, White, atc. Specify: Black
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 6th	CATION completed) College (1-4 or 5 +)	16a. DECEDENT' (Give kind of life. Do NOT House	work done duse retired.)	luring most of working	16b. K	DOM	ness/indus	
ш	17. FATHER'S NAME (First, Middle, Last) Unknown					NAME (First, Mid ristir			
TO B	19a. INFORMANT'S NAME (Type/Frint) Clara Bivens				(Street and Number or Run yle Aven				
	20a. METHOD OF DISPOSITION 1 N Burtal 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	V	PLACE AND DATE etery, cremetory or OShell	Mem	TION(Name of 2/2/orial Gar	dens	Bal	timor	ry or Town, Stata
	21. SIGNATURE OF FUNERAL SERVICE LA). Dult	+	²² L 4	eroy 0. D 600 Liber	yett ty He	& Son	n Fur	neral Home Balto, MD
	23. PART I. Efter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cluse on e	ach line.		the mode of dying, so				Approximate interval Between Onset and Death
z	resulting in death)	DUE TO (OR AS A							
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Olsease or Injury	ODE TO ON SA	CONSEQUENCE	OF):					
	thet Initiated events resulting in desth) LAST	DUE TO (OR AS A	CONSEQUENCE	OF):					
EDICAL C	PART II. Other significant condition		ut not resulting		derlying cause given		4e. WAS AN A PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH Y	ES 1	NO UNCERTA	MN 🗆			1 YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp	26. PLACE OF DE	OTHER		e 6 🗆 Other (Specify)		
у РНУ	27. MANNER O DEATH 1 Natural 5 Pending Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b. Ti	1 4 5 4 5	28c. INJURY AT WORK? 1 YES 2 NO	7	RIBE HOW IN	JURY OCCU	RED
ED B	2 Accident Investigation 3 Suicida 6 Could not be determined	28s. PLACE OF INJURY building, atc. (Spec	At home, farm	, street, facto	ory, offica	26t. LOCAT City or	ION (Street as Town, State)	nd Number or	Rural Route Number,
OMPLET		ICIAN: To the best of my know							j. cause(a) and manner ea stated.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Gracito V. Patricio, M.D.P.A. 703 S. Clinton Street, Baltimore, Md. 21224

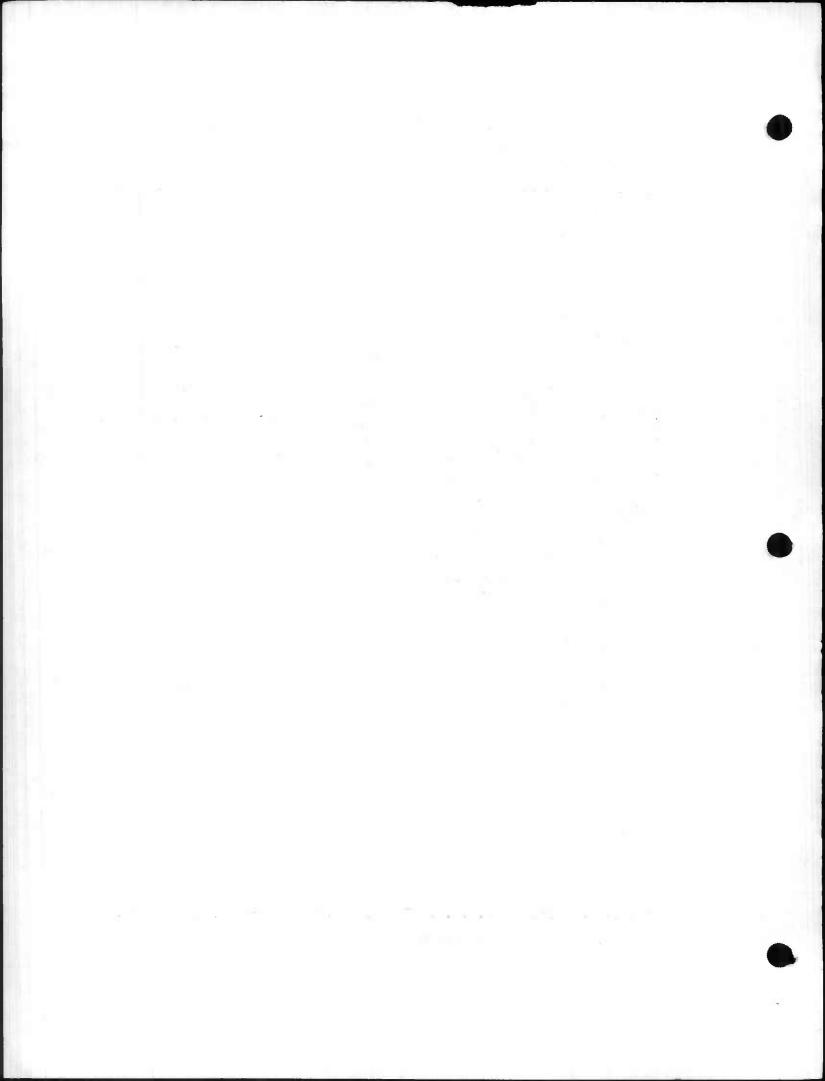
29c. LICENSE NUMBER

D08358

FFB 0 2 1998

29d. DATE SIGNED (Month, Day, Year)

1/29/98



State of Marylan

Certificate of Death	Reg. No.	0258
id / Department of Health and Menta	Il Hygiene	0000

og physician end es the burief-tren certificate be exec Box 68760 USB signed by the e Division of Vital Records, page 2 s certificate hes Physician: director, this funerel After

36 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Data of Deeth JANTARY 28, 1998 **Physician** Stanley Warren Jones 00:20 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner 2214 WICOMICO STREET n/a BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 220-30-0219 7. Aga (In vrs. last birthday) 6 Sax Birthplece (State or Foreign Country) **Funeral** 117 M 2□ F 63 Yrs. 1/29/1998 Maryland Director Usual Rasidanca of Dacedant 10a. Steta 10b. County 10c. City, Town or Location 10d. fnslde City Limits permit. Peges 1 end 2 should be filled within 72 hours efter death with the Meryle Department of Health end Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f ehow any Injury or other traumatic event, in Mexical Expiriment must be not the doce. MD n/a 1K Yes 2 No Baltimore Directo 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 2214 Wicomico St. 21230 United States Funeral 12. Wes Decedent Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 1 Dyas 2 No1952— If Yes, Giva Yeer or Dates: 1955 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Collaga (1-4or 5+) Personel Supervisor Restaurante 12 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley MOrris Jones Ruth M. White 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Raletionship (Type, Print) Grace Elizabeth Jones 2214 Wicomico St. Baltimore, MD 21230 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 1/29 Glen Burnie, MD 4 ☐ Donation 5 ☐ Othar (Specify) Glen Haven Cemetery 22. Name and Addrass of Facility Ambrose Funeral Home of 21. Signatura of Funaral Samue License Landowne 2719 Hammonds Ferry Rd. Lansdowne, MD 21227 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Intervel Betwaan Onset and Daath Physician Immediate Causa (Final disaasa or condition rasulting in daath) /Medical · HYPERTONSIVE ATHORISCIENCIC CANDIOVASCULOS Examiner Due to (or es a consequence of): Examiner 15/AS0 Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Ceusa (Disaasa or Injury that initiated avants Due to (or es e consequence of) Physician/Medical Due to (or es a consequence of): rasulting in death) Last Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobecco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailabla prior to complation of cause of death? 24e. Was an eutopsy performed? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to madicat axeminar? Be 26. Plece of Death (Check only one) 1 Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA ^oL 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28d. Dascribe how injury occurred 28c. Injury et Work? Certification: To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: After 1 Netural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarminad 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) illed in by 4 1 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the ceuse(s) end menner es steled.

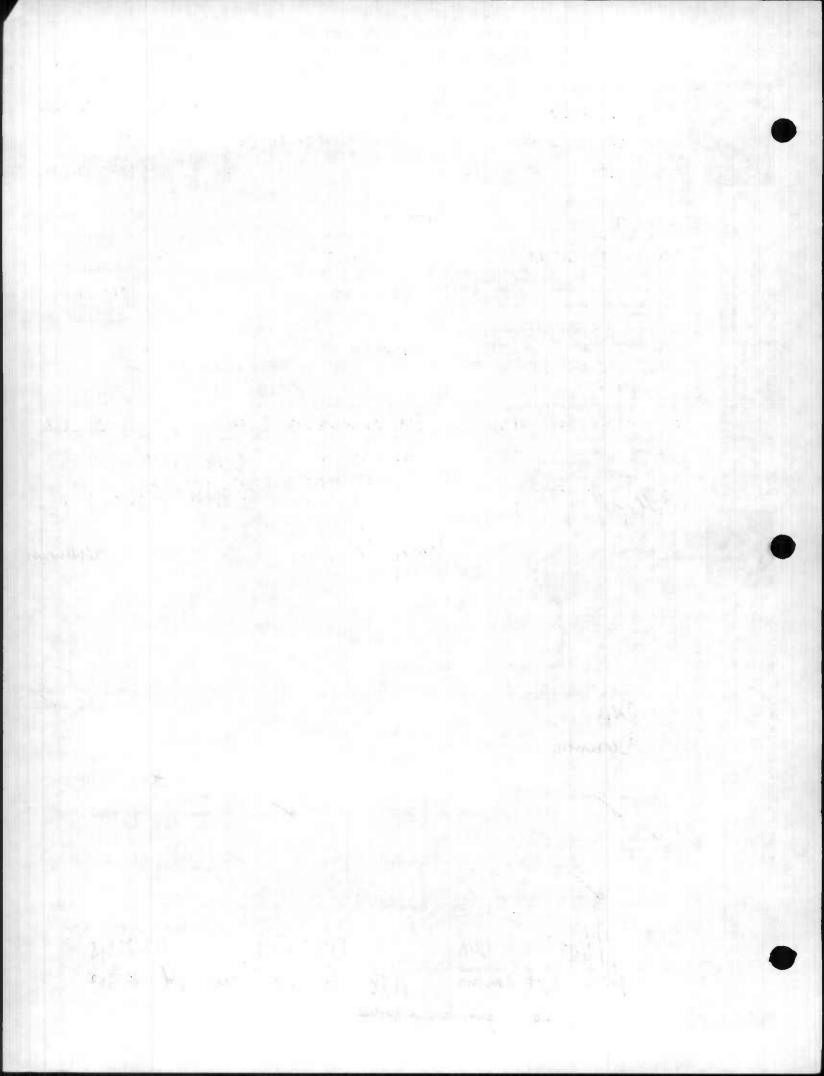
Wedical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29a. Certifier Medical completely (Check only one) 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier OCME JANUARY 26, 1998

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type Print)

Street, Baltimore, Maryland 21201 JARYDAMA 31. Data filad (Month, Day, Year) State FEB 0 2 1998 Registrar

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32. Registrar's Signatura Ma Davidson State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 24, 1998 **Physician** JANUARY 5: P.M. Robert Johnson /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner OF **EVERGREEN** BALTIMORE INNS N/A If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) JUNE 11, 1922 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 1 M 2□ F Deys Hours 75 EASTERN SHORE, VA Yrs. 270-05-7998 Director Usuel Residence of Decedent with the Maryland 10e. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 Yes 2 No Directo MARYLAND BALTIMORE 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code pemit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itema 23a
any Injury or other traumatic event, the Medical Exercises 23a
any Injury or other traumatic event, the Medical Exercises 23a
any Injury or other traumatic event, the Medical Exercises 23a
any Injury or other traumatic event, the Medical Exercises 23a 2416 MADISON STREET USA 21217 Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: AFRO. AMERICAN Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN UNKNOWN 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) UNKNOWN UNKNOWN 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1341 WOODYEAR STREET, BALTIMORE, MARYLAND 21217 ca of Disposition (Name of Date 20c. Location - City or Town, State ADAM WITHERSPOON FRIEND 20b. Pleca of Disposition (Neme of cemetery, cremetory or other placa) 20a. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State MT. ZION CEMETERY 1/29/98 LANSDROWN, MD. 4 Donetion 5 Other (Specify) ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 If disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, in failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** tmmediate Ceuse (Final disease or condition resulting In death) /Medical Unknown Examiner Due to (or as a co equenca of) Examiner physician end the burial-transit The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequenca of): 98 ettending p signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by been sig 24a. Was an autopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed has: is certificate has 1 Yes 2 No 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Deeth Certification: After 1 5 Pending investigation Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital or At 24 hours after ce Funeral Directletely filled in by 4 Homicide 112 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and plece, and due to the ceuse(s) end menner es stated.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end manner stated. 29a. Certifiar edicai (Check only one) To the I within 2 To the I complet 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M d cause of death (Item 23a) (Type, Print) 30. Name and adg emun 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State wha Davidson FEB 0 2 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02588 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Month Day 24 1998 JONES MARY Μ. 4b. City, Town, or Location of Daath 4a. Facility Nama (If not Institution, give street and number) 4c. County of Death | Hunder 1 Yaar | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | 3/6/08 Maryland 7. Aga (In yrs. I GENERAL 5. Social Security Number st birthday) 9 Birthplaca (Stata or Foraign 1□M #□F 89 244 09 4805 Yrs N.C. Usual Rasidance of Decedent 10c. City, Town or Location 10d. inside City Limits 10b. County BALTIMORE # Yas 2 No N/A 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 819 N. BENTALOU ST. 21216 USA 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 11. Maritat Status 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married SpecifyAFRO AMERICAN 1□ Yas #□ No 3 d Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilega (1-4or 5+) CROWN, CORK AND SEAL LINE PERSON (RETIRED) 17. Fathar's Nama (First, Middia, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) SAM MARTIN LIZA MARTIN 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stete, Zip Code) LAURA JONES DAUGHTER 819 N. BENTALOU ST. BALTO. MD. 20b. Piaca of Disposition (Nama of cometany, crematory or other place) EADEN GARDEN 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Bunal 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donatton 5 □ Othar (Specify) 1/30/98 REIDSVILLE, N.C. 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTIMORE, MD. 23a. Part 1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata intarvai Batween Onsat and Death immediata Causa (Final disaasa or condition rasulting in daath) neumonia Dua to (or as a consequence of): rai Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in deeth) Last Dua to (or as a co Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

MD.

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r than "natural", or items 23a or the Medical Examiner must be r

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

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Department of Important: If it any injury or o

Jones, MARL

Examiner physician and the buriel-transit Physician/Medical use as signed by the at d be deteched for by Completed hes page 2 certificate Be 10

The law requires that the death certificete be executed

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

this

funeral director, Certification:

To the Hospital or Attending within 24 hours effer deeth.

To the Funeral Director: Affe completely filled in by the funy

State Registrar

Medical

Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yas 2 ☐ No 25. Was casa raferrad to madical axaminar? 26. Placa of Death (Check only ona) 1 Yas 2 No Othar: Surring Homa 5 Rasidance 6 Othar (Specify) 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28h Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Naturai 2 Accidant 5 Panding invastigation 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 3 Suicida 28a. Placa of injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 4 - Homicida 29a, Certifian (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) end mannar es stated.

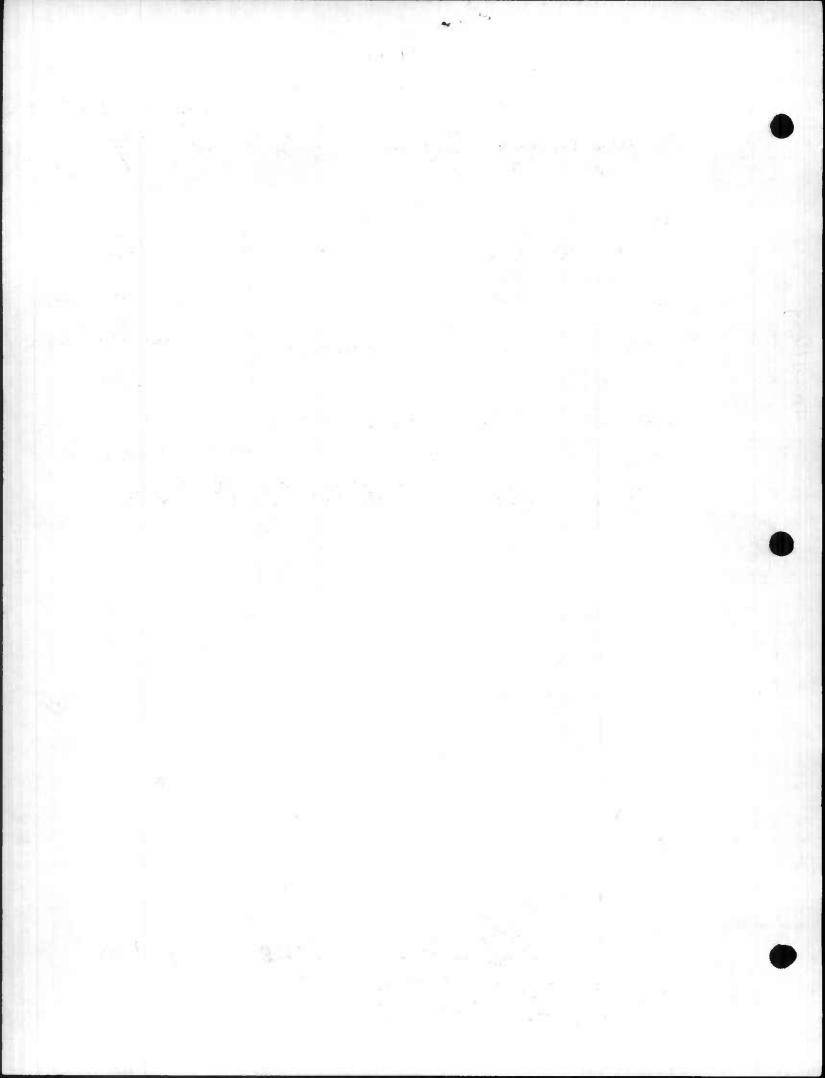
2 Medical Examinar: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

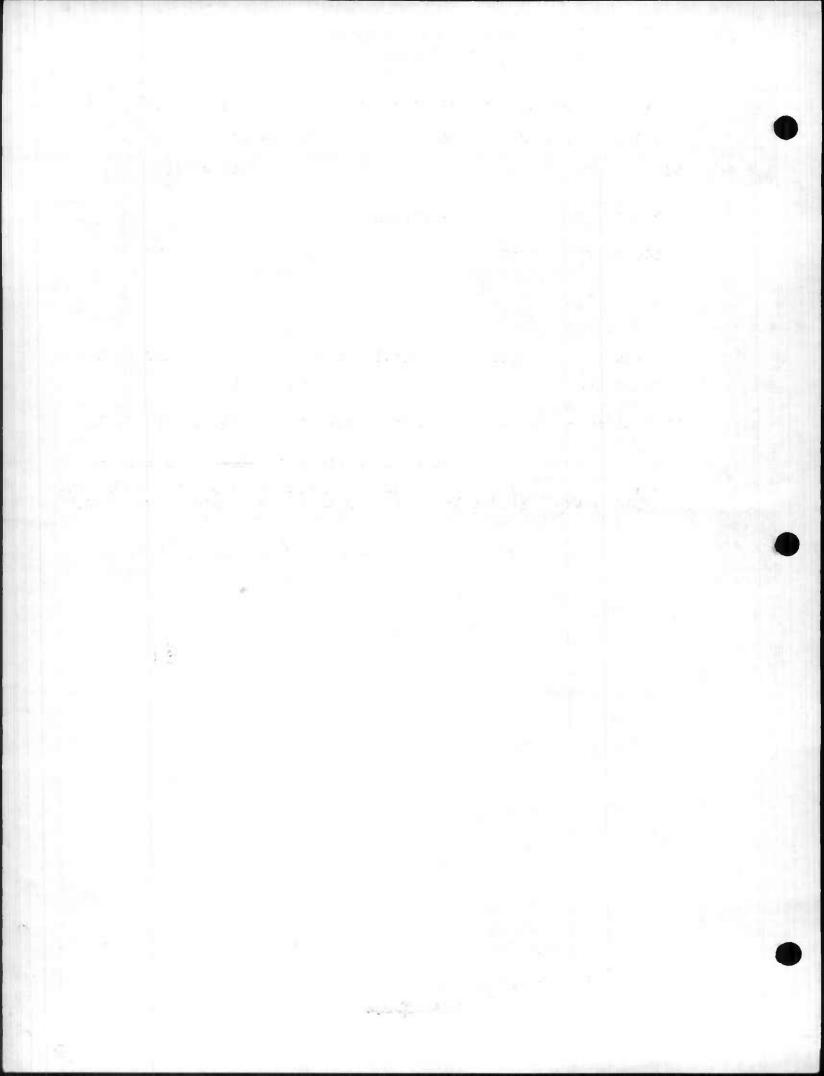
0 MARYLAND GENERAL HUSPITAL 1. D. Go MARY Q x 32. Registra's Signatura Andrew Randall

FEB 02

29b. Signatura and titla of certifiar



		H G-756 2/2/98 dh 1. Decedent's Name (First, Middle, Li	ast)		Cer	tificate of	Death	2. Dete of De	Reg. No.	U	3. Time of Deeti		
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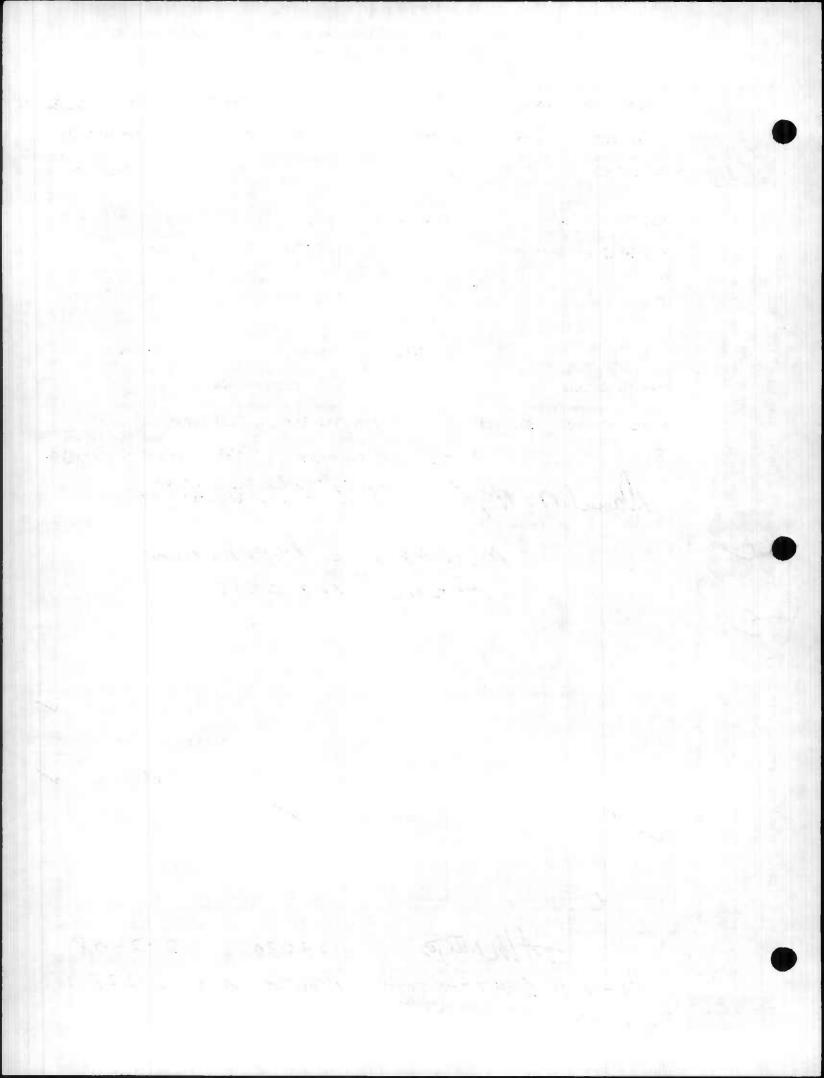
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Baltimore, figure permit. Pages 1 end Department of Health Important: if item 27 important or other tonce.		21. Signature of Fund	4 Donation 5 Dother (Specify) King Memorial Park 1-31-98 Randallstown, Md 22. Name, and Address of Facility March F/H West												
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VITAI MECOTOS, Publica: The law requires that certificate has been signed by inector, page 2 should be dete	Completed										sen eutopsy ormed? 24b. Were eutopsy findings available prior to completion of cause of death?				to
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0		30. Name and addres	s of person who co	mpleted cause of	death (Item	23a) (Type.		- T	1.40		/	~	2 ~	(X	
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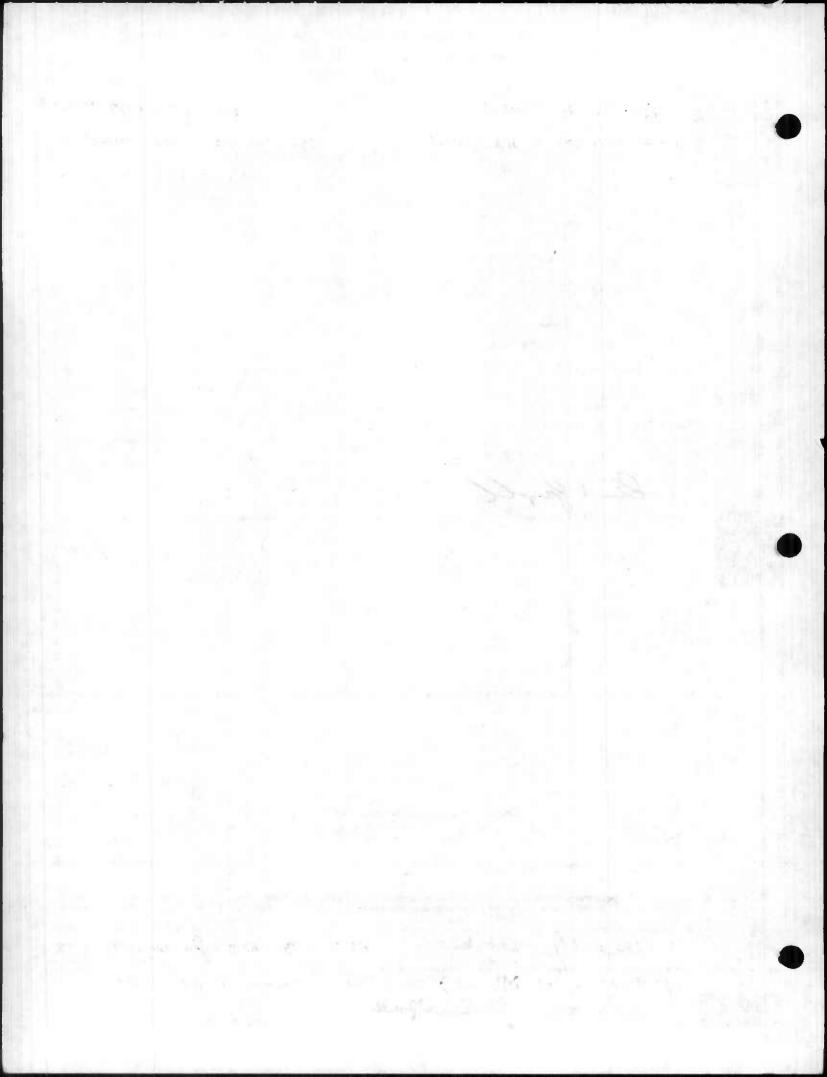
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uneral irector	5. Social Security Number 6. Security Number 1		n yrs. lest birthday) O Yrs.	If Under Months	1 Year Deys	Hours	Min	(Month, De	(Month, Dev. Yeer) Country)				
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or 28a-fa be notified Director	10e. Street end Number		Daronio	10f. Zip	Code				10a. Citizen of	Whet Count	rv?		
rai Di	1522 Williams St				2	1230			USA				
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merico To	19a, fnformant's Name/Reletionship (7	Type Print)	10h Mailie	a Addraes	/Street				er City or Town	State Zin	Code)		
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should should		,						24a. Wes	en eutopsy ormed?	con	npletion of cause		
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certificate has rector, page 2 Be Comp	25. Was case referred to medical examiner?					26. Plece	of Deeth	h (Check only	one)	1			
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o the	29b. Signeture end title of certifier	11.		290	. Licens	e number			29d. Date sign	ed (Month, L	Dey, Yeer)		
F 0	-	Alland	you	d	92	35.	30		2-3				
1	30. Name encyliddress of person who completed cause of death (Item 23e) (Type, Print) H. H. K. K. L. HATTH JEE PSALL M. 2/2.												
6	30. Neme end address of person who o	completed cause of death	(Nem 23e) (Type,	Print)	13	ALZ	1	ms	21	227	7		



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show		10e. State 10b. County		10c. C	ity, Town or Lo	ocation				10d. 1	nside City Limits		
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or 28a-f	irec	10e. Street end Number	4.1			10f. Zip Code	CIMOLE		10g. Citizen of	Whet Country?			
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Depertmen Important: any injury once.		21. Signeture of Funeral Service Lic	эрине /	/		Name end Add	ress of Fecility	tw of	MD Tn	0			
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ysician Medical kaminer		23a. Pert1. Enter the disease, or co shock, or heert feilura. List on Immedieta Ceuse (Finel disease or condition resulting in death)	est la	TRO			ing, such es cerdia	c or respiretory e	rrast,	Inta	roximete rval Between set end Death		
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rs effer death. al Director: At led in by the fu	Certif	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homlcide determine	28e. Place of	Injury - At h , etc. (Speci	oma, farm, stri	eet, factory, office		28f. Location (: City or Tox	Street and Num! vn, State)	ber or Rural Rou	rte Number,		
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To to the total to the total t	2	29b. Signeture and title of certifier	In Res	た		se number 2 4 0 2 3 2 1		29d. Date signe		998			
6		30. Name and address of person with ALBERT 5. 31. Date filed (Month, Day, Year)	Print) , JIMA?	402321 HOSPP	AL OF	BALTUM	ort						

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 1:55 An ARL EDINA 194 31 /Medical 4e. Facility Neme (If not Institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Hospita Hanes Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) **Funeral** 1□M 2☑F 76 Yrs. Director 217-16-5984 June 13, 1921 Maryland Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Madical Examiner must be notified at 10d. fnside City Limits 1 XYes 2 No N/A Baltimore Directo Maryland 10e. Sfreef and Number 10f. Zip Code 10g, Citizen of Whet Country? with 1251 Haverhill Road 21229 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11 Maritel Stetus 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: b 3 ₩ Widowed 4 Divorced Completed 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry be filed within 7 lal Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) unk Sales Clerk Department Store permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Daniel Oliver Edna Mallonee 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley Hedges / Daughter 1251 Haverhill Rd., Baltimore, MD Baltimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1

Buriel 2 □ Cremation 3 □ Removel from State Meadowridge Memorial Park 2/4/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Loudon Park Funeral Home 21. Signature of Funerel Service License 3620 Wilkens Avenue, Baltimore, MD cations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, 1. Enter the disease, of complications that caused the mean feilure. List only one ceuse on each lin **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting In death) neumonia Week Examiner Due to (or es e consequenca of): Examiner physician end the buriel-trensit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieled events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or as e consequence of) ettending USB Pert II. Other algorificant conditions confributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown thrombosis Dayetes þ been si 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? s certificate has be director, page 2 s 1 Tes 1 ☐ Yes 2 No Division of Vital 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 ☐ Yes 22 No 27. Manner of Deeth Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To this funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Aftar 1 Naturel 5 Pending 1 Yes 2 No deeth. 2 Accident Investigation or Attendette of the other of the other of the other of the other of the other of the other of the other oth 6 Could not be determined 3 ☐ Suiclde 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homlcide To the Hospital of within 24 hours of To the Funaral D completely filled in 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

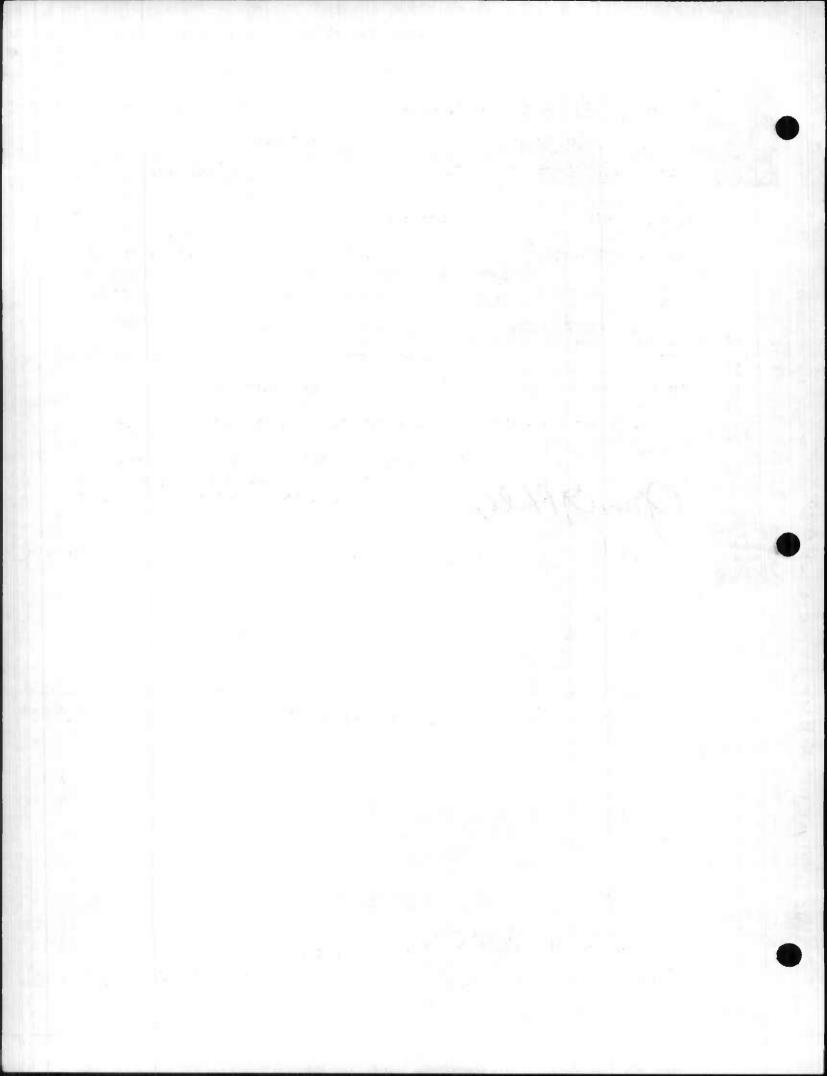
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Cartifier cai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature Kouls Ne, MD D46704 ahmon 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) ST ACN CS HOSPITAL 32. Registrer Signature

Q Suha Davidson-Randsle 31. Date filed (Month, Dey, Yeer) State 1998 Registrar

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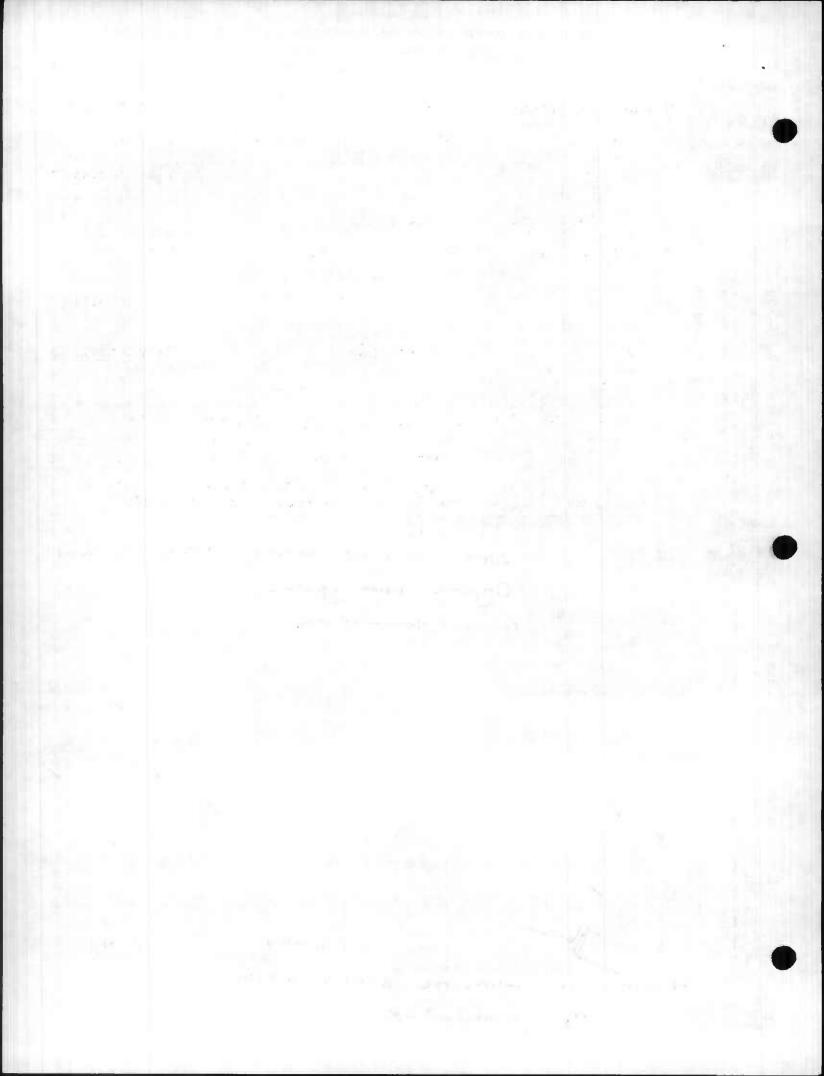
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State of Maryland / Department of Health and Mental Hygiene

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* anthony (Metro	Crem	atory	19	98 (Catons	ville,	MD				
Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 23a. Partl. Enter the disabled or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest. Approximate													
23a. Part1. Enter the disagret or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilum. List only one cause on each line.													
													shock, or heert feilure list only
mmediate Cause (Finel					lun our oer et	dise	100						
lisaasa or condition esulting in death)	e. Chimic Orasinacine							401	1-3				
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sequentially list conditions,	00												
if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted avants rasulting in death) Last Due to (or es e consequence of):													
nat initieted avants	D	ue to (or es e co	nsequence o	f):				į					
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the contribute to t													
art II. Other algnificant conditions of	ontributing to death but	not rasulting In	ha undarlying	g causa givan in	Pert I.	23b. Did to	bacco use con	tribute to the c	nues of death				
The state of the						1 🗆 Ye	e 2□ No	3 Probably	4 Unkno				
						24a. Was ar	autopsy	24b. Wara aut	opsy findings				
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				26.	Placa of Death (Ch	eck only one	9)						
1 Yas 2 No	Hospital: 1 Inpatian	t 2 ER/Outp	atient 3	DOA Other: 4	☐ Nursing Home	5 Rasida	nca 6 Othe	ar (Specify)					
	28a. Date of Injury	Vaar) 28b. Tii		28c. Injury at	28d.	Dascribe ho	w Injury occurr	ed					
		7 00.7	М		2 🗆 No								
	28e. Place of Injur	y - At home, farr	n, street, fect	ory, offica	28f. I	ocation (Str	aet end Numb	er or Rural Rout	a <i>Number</i> ,				
4 LI Homicide	building, etc.	(Spacify)				ity or I own	, Stata)						
9a Cartifiar 1 Cartifying Ph	velcien: To the hest of	my knowledge	death occurre	ed et the time de	ate and place, and o	lua to tha ca	usa(s) and ma	nnar as stated					
(Check only 2 Medical Exam	ninar: On the basis of e	xeminetion and/	or invastigetie	on, in my opinior	, death occurred at	tha tima, da	ite end plece, e	end due to tha co	ause(s)				
	and mannar state	50.		29c Licansa nun	nher	20	d Date signar	d (Month Day Y	'ear)				
Commence and min Programme						23			/				
1/00		0 30444											
b Do													
0. Nama and edd of person who	complated causa of dec	eth (Item 23e) (T	ype, Print)		MD ZKK								
	25. Wes case referred to medical axaminar? 1	Sequentially list conditions, lany, leading to immediate ause. Enter Underlying Cause, (Disassa or Injury hat initieted avants asulting in death) Last 2. Sequentially list conditions. Description: Sequentially list conditions, lany, leading to immediate ause. Enter Underlying Jausa (Disasa or injury hat initieted avants asulting in death) Last Tart II. Other algnificant conditions contributing to death but not resulting in the saminar?	Sequentially list conditions, any, leading to immediate ause. Enter Underfying Jausa (Disasa or Injury hat initieted avants asulting in death) Last Set III. Other algnificant conditions contributing to death but not resulting in the underlying aximinar? 1	Due to (or as a consequence of):	Sequentially list conditions, lardy, lasding to immediate subsets of injury and initieted evants assulting in death) Last Due to (or as a consequence of): **Colvular Neart Alignment Conditions** Due to (or as a consequence of): **Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): **Due to (or as a consequence of): Due to (or as a consequence of): **Due to (or as consequence of): **Due to (or as consequence of): **Due to (or as consequence of): **Due to (or as consequence of): **Due to (or as consequence of): **Due to (or as consequence of): **Due to (or as consequence of): **Due to (or as consequence of): **Due to (or as consequence of): **	Sequentially list conditions, lany, leading to immediate ause. Entor Underlying ause (Disease or Injury hat initieted avants asulting in death) Last Due to (or es e consequence of): Valuar Neart Alseanc Due to (or es e consequence of): d. Due to (or es e consequence of): d. 23b. Did to the contributing to death but not resulting in the underlying cause given in Pert I. 1 Ye 24a. Was are parform 1 Yes 25. Was case referred to medical avaminar? 1 Yes 21s No 1 Namper of Death 1 Nebutral 28a. Date of Injury 28b. Time o	Sequentially list conditions.	Sequentially list conditions, larly, laading to immediate auss. Enter Underlying Just (or as a consequence of): Congative Near + fouture 1/2 1/					

DHMH 16 Rav 6/95



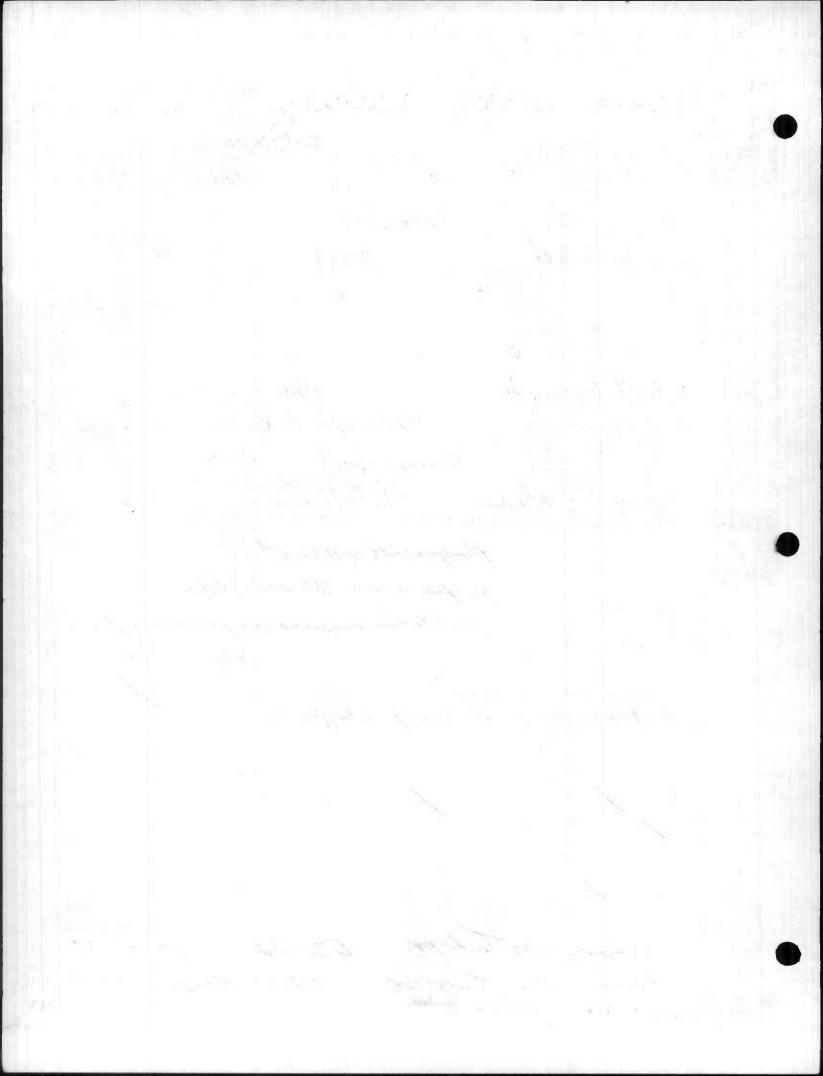
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 0100 /Medical te. Facility Neme (If not institution, give street and number) 4b. City, Toy or Location of Death 4c. County of Death Examiner Pita 5. Social Security Number If Under 1 Year If Under Months Days Hours Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** -13-7025 1 M 20 Director 2/03/1985 Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Pres 2 No Director 04/timore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ò items 23a 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ 100 If Yes, Give Yaar or Dates: 11. Marital Stetus Was Decedant of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indien, Bleck, White, etc. 1 Never Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: by Specify: HTTICAN-AMERICAN 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pemit. Peges 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Item 18 Elementery/Secondery (0-12) Coilege (1-4or 5+) Never worked worked 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Surname) Be Mary E. Williams Lowery Jr. 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mrs Mary E. Lowery Carnation 20a. Method of Disposition 20c. Location - City or Town, Stata 1 DBurial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Uwings Milks, Md. COURTISON 21. Signature of Funerel Service Licensee funeral 23a Furth. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, and a respiratory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest P.O. Box 68760. Physician/Medical been signed by the attendin should be detached for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24e. Was en eutopsy performed? 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? , page 2 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examinar? 26. Piece of Deeth (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation within 24 hours efter death. To the Funeral Director: A 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as steted.
2 Medical Exeminer: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated. Medical 29a. Certifier (Check only one) To the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

State 31. Date filed (Month, Day, Year)

M. TRUBE IM

SINDS HOSPITAL OF BALTA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q R Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Francis 0. Lemon 12:01 Am JAN 30 /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HoSpita 6. Sex Balt, If Under 24 Hrs. agnes If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) Deys Hours 1₩ 2□ F Yrs. 221-09-3309 86 Mar. 27, 1911 Delaware Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. tnside City Limits 1 Yes 2 No MD. Baltimore Director Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5906 Franklin Ave., Apt. 3F 21207 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Rieck White etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No þ Specify: white 3 ₩idowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) barber 12 17. Fether's Neme (First, Middle, Last) barber shop 18. Mother's Name (First, Middle, Meiden Surneme) Be Joseph Lemon Catherine Harkins 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Richard Lemon, son 2449 Hammond Pl., Wilmington, Delaware 19808 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore/Washington Crem. 2/1/98 Laurel, Md. 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Witzke Funeral Homes, Inc. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac of respiratory arrest, MD shock, or heer feiture. List only one ceuse on each line. Lemmer 21228 Approximate Immediete Ceuse (Finel diseese or condition resulting in death) PULMONARY EMBOL LIM 244 Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) Pert il. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown DEMENTIA, (ORONARY ARTERY by DISEASE, HYPERTENSION 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? No No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospitel: ↑ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one)

29c. License number

00052101

900 CATEN AVE BALTIMORE

Box 68760 - CMON

> State Registrar

Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Mountal Examinar must be notified at

permit. Peges 1 and 2 should be filed within Department of Heelth end Mental Hygiena. Important: If Item 27 is marked other than any Injury or other traumatic average.

Physician /Medical

Examiner

physician end the burial-transit

signed by the a

certificate

After

Director:

To the Hospital of within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0020

31. Dete filed (Month, Dey, Year) FER 0 2 1998

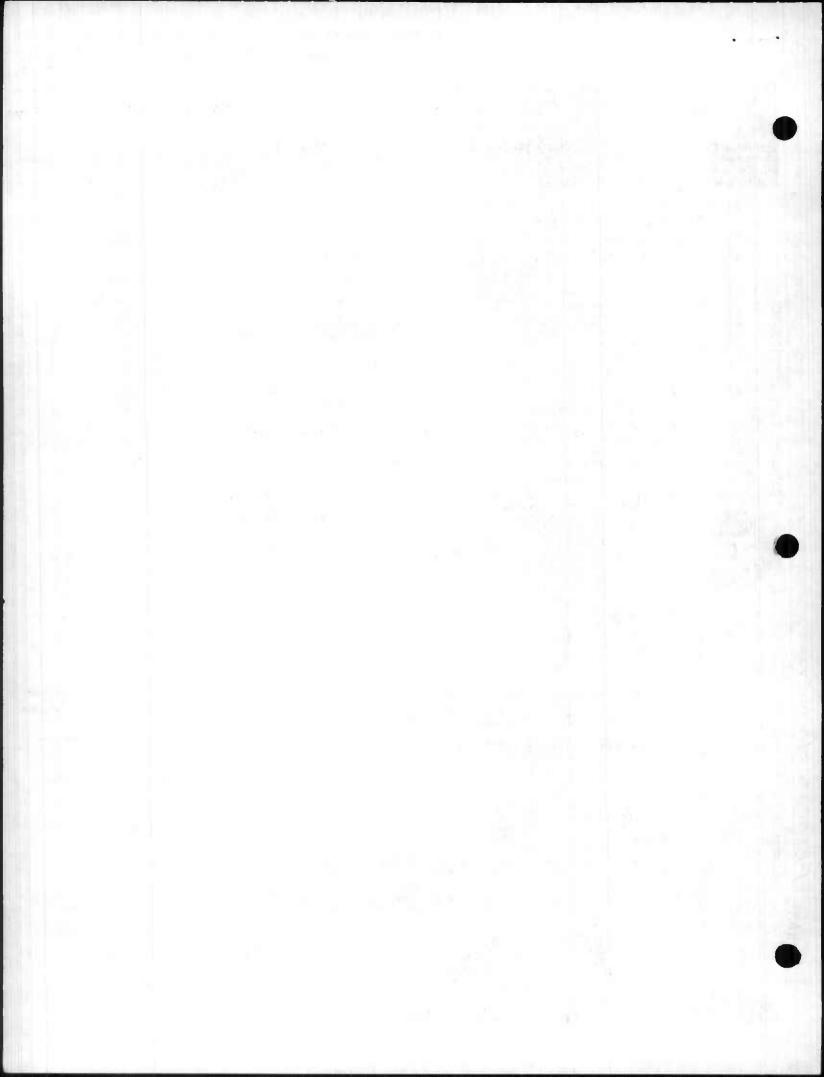
29b. Signature end title q

NORBERTO CALIADA, MD 32. Registrer's Signeture Pulis Devidson-Randelle

M. D.

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95



Month **Physician** SALVATORE 0430 am LIPIRA JANUARY 1998 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALTNES BUITIMORE n/a HEALTH CARE If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□ F Yrs Director 217-38-4743 Oct. 24 1919 Italy Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Llmits 28a-f show traumetic event, the Medical Examiner must be notified at 1 Yes 2 No MD. Baltimore Director Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 6206 Chesworth Road 21228 U.S.A. items 23a death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter onent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "netural", or ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tailor clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincenzo LiPira Rosa **Brocato** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6206 Chesworth Rd., Catonsville, Md. 21228 Rose LiPira, wife other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 6 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State permit, Page Department of Important: If any Injury or 2/2/98 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Cemetery Eldersburg, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21228 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Respiratory Failure Minuser Examiner Due to (or as a consequence of): Iner days Heart Congestive Failnize icien end buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physicien use as the burie Failure Renal Physician/Medical Due to (or as a consequence of): use as CoRonary Merry montes Disease etten Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown p Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 hes After this certificate 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1⊠Inpatient 2□ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural deeth. 1 ☐ Yes 2 ☐ No 2 Accident after deeth 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.D. JANWARY P11698 29, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rupesh ParkiKh 21229 900 Caton Bultimore, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 2 1998 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Deeth

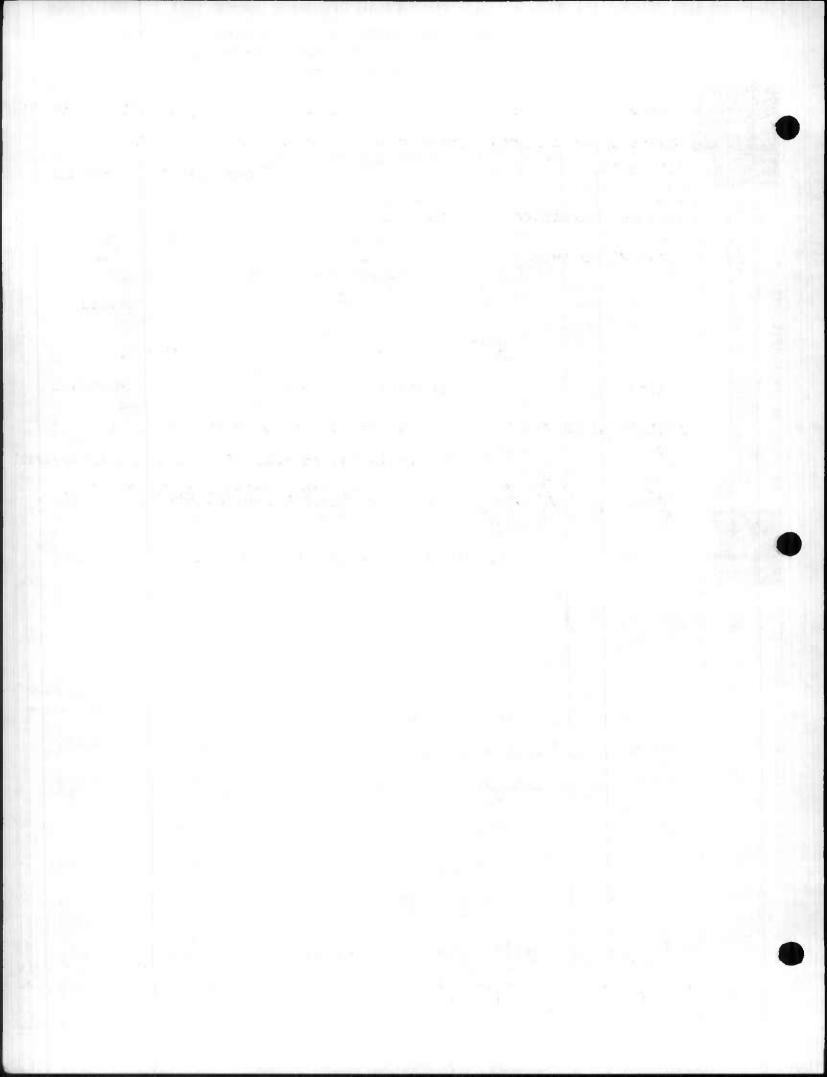
3. Time of Deeth

1. Decedent's Neme (First, Middle, Last)

4.1

State of Maryland / Department of Health and Mental Hygiene 8 0 2 5 9 8

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Exami		4e. Fecility Name (If not institution, g	ive street and number)			4b. 0	City, Town,	or Location of Death	4c. Co	unty of Deeth		
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within 72 hours after deeth with the Meryland ene. than "natural", or items 23e or 28e-f show the Medical Exercine rrust be nighted at	by Funeral Director	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2 XNo If Yes, Give Yeer or Dates:	er in U,S.	13. Wes Deceden If Yes, specify 1 □ Yes 2 🖫	Cuben, N	anic Origin' Mexican, Pi Specify:	(Specify Yes or No uerto Rican, etc.)		Rece - Ameri Bleck, White, ecify: Wh:		
"naturai",	Completed	15. Decedent's (Specify only highest of	Education	16e. D	ecedent's Usual C	Occupatio	ing most of	working	16b. Kind	of Business/In	dustry	
be filed within 72 ha ital Hygiene. d other than "natui event, ine Medical	npie	Elementery/Secondery (0-12)	College (1-4or 5+)	7	Give kind of work of ife. DO NOT use i	retired)	rig illost or	Working				
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		19a. Informent's Name/Relationship	(Type, Print)	19b. N	Meiling Address (S	Street end	Number o	Rural Route Number	er, City or To	own, State, Zip	Code)	
= 01 -		Phillip Lipka	(Son)	67	33 Fift	h A	ve.	Dundalk,	Md.	2122	2	
f of Heal		20e. Method of Disposition 1 Burial 2 □ Cremetion 3		20b. Plece of D cemetery,	Disposition (Name cremetory or other	of er place)		Dete	20c. Locat	ion - City or To	own, State	
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xaminer		diseese or condition resulting in deeth)				au	LC 1	diseas	(1	weeks	>
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efter deeth. Diractor: After	tific	3 ☐ Suicide 6 ☐ Could not determine	286. Piece of injury	- At home, farm	, street, factory, o	ffice			ocation (Street and Number or Rural Route Number, city or Town, State)			
s efte	Certification:	4 El Monioldo	building, etc. (specify)				City of 700	ni, State)			
24 hours Funeral		29a. Certifier X Certifying F	hysician: Το the best of π	ny knowledge, d	leeth occurred et t	the time, o	date end pl	ece, end due to the	ceuse(s) end	d menner es s	teted.	
hin 24 the Fu	edicai	(Check only 2 Medical Exa	miner: On the besis of ex end menner stated	aminetion and/o J.	or investigetion, In	my opinio	on, deeth o	ccurred et the time,	dete end ple	ice, end due t	o the ceuse(s)	
within 24 hours efter deeth. To the Funeral Diractor: After completely filled in by the funer	M	29b. Signeture end title of certifier			29c. L	icense nu	mber		29d. Dete si	igned (Month,	Day, Year)	
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A		30 Name Town	JULIUV8 VV	100 0000	De (20)	0 41	169	-	JAMIA	1/2/	6. 0	,
()		30. Name and address of person who	completed ceuse of death	n (Item 23e) (Ty	/pe, Print)	. +	T	RRACE lei	16.	aclo	TINS ISA	Y
		31. Dete filed (Month, Day, Year)	CHNS HOPKIN	is bearing	Allics Lo	en (e)	1-10	RRACZ lei	141	Altim	una, Md	41
Sta			32. Hegistrerie	Signature Widow-A	indell							
Registr	di	FEB 0 2 199	10									



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygierie 3 Certificate of Death Item 4a per FH Film G756 2-2-98 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** 28 1888 Jan. Wesley Thomas Myers 5:53 mm /Medical 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 804 Rambo-Cout-Lansdowne Court Baltimore H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 30,1949 Maryland 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 216-52-9122 10XM 2□ F 48 Yrs Director Usual Residence of Decedent the Marylend 10a State 10h County 10c. City, Town or Location 10d, toslde City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumetic event, the Modical Examiner must be nothled at Maryland Baltimore 1 ☐ Yes 2 No Director Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 Rambo Court 21227 United States death Funeral 12. Was Decedant Evar in U,S. Agned Forces? 1'⊡ Yes 2 □ No If Yas, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer o Independent of Health and Mentel Hygiene. Important: If Item 27 Is marked other than "naturel", or item any injury or other traumatic event, the Modical Examinations. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Sales 12 Automotive Parts 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be Albert G. Myers Mary E. Dobson 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) Debra L. Myers, wife 804 Rambo Court Lansdowne, Maryland 21227 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Spacify) 1/30/98Catonsvillee, Mary 21. Signature of Faneral Service Licensee 22. Nama and Addrass of Facility
Ambrose Funrral Home of Lansdowne 2719 Hammonds Ferry Road Maryland21227 23a. Part1. Enter the disaasa, or compilations that caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Betw Onset and Death **Physician** /Medical tmmediate Cause (Final respitatory disease or condition resulting in death) Examiner Physician/Medical Examiner Gastinz CA physician and s the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by t should be detect 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s this certificate 1 Tyes 1 ☐ Yes 2 ☐ No of Vital 25. Was casa referred to medical examiner? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No deeth. I Director: A 21 Accident 6 Could not be datermined 3 ☐ Suicide 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) efter 4 Homicide To the Hospital
within 24 hours e
To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examinar: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler 29b. Signature and titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 2 1998

Zercz, Ph.D., M.D. 7672 BELAIR ROAD BALK, Md. 2/236 Charles 1. 32. Figistrar's Signatura
Javidson-Randelle

Private Physician

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

050958

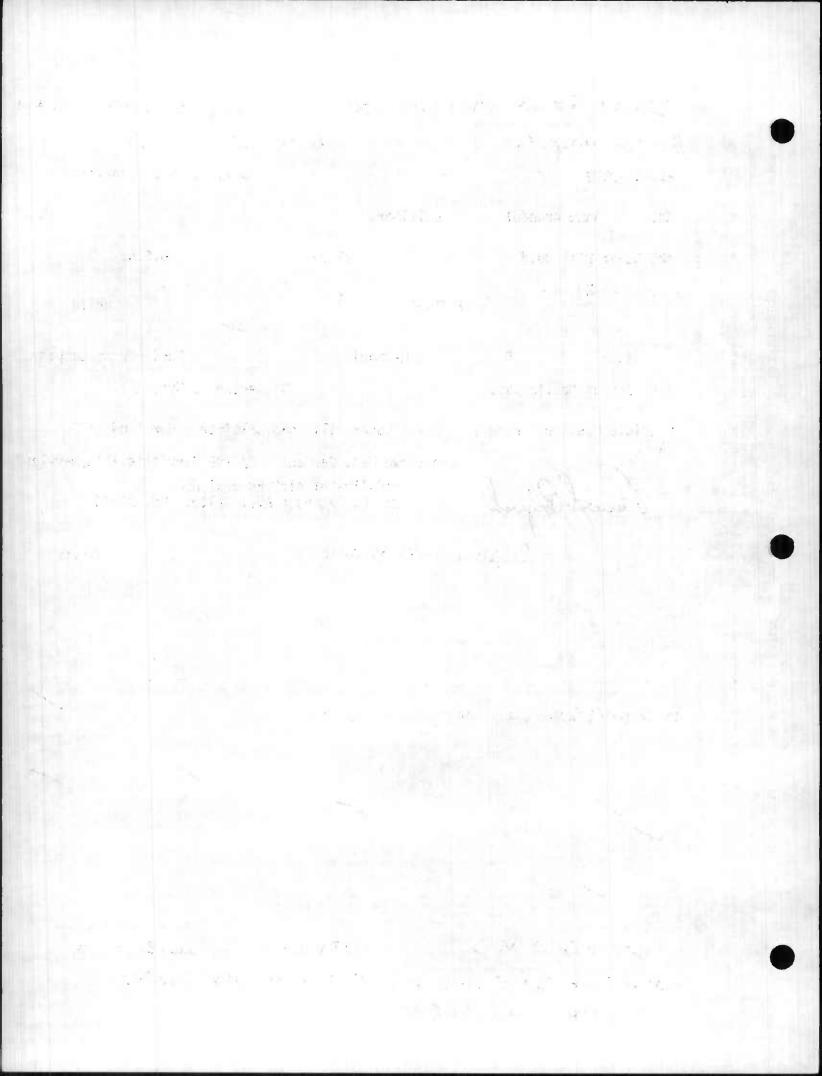
16. 3a - 10. C. Janes 19. a territoria

State of Maryland / Department of Health and Mental Hygiene 8 0 2 6 0 0

Certificate of Death

			C	ertificate o	f Death	R	eg. No.	0 4	000	
Physician	1. Decedent's Name (First, Middle, Las					2. Date of Deet Month	Day	Year	3. Time of Death	
· /Medical	David tra	me Mue	ller	2		Jan	31 19	99	2-38 AW	
Examiner	4a Facility Neme (If not institution, give	street and number)			4b. City, Town, o	r Location of Death	4c. County			
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Funeral	5. Social Security Number 6. Se	M OFF	s. last birthda Yrs.	Months Day		(Month, Day,	Year)		ace (State or Foreign ry)	
Director	219-38-2179 Usual Residence of Decedent	56)			July 3,	1941	Mary	land	
ž 11	10a. State 10b. County	10c.	City, Town or	Location				10	d. tnslde City Limits	
tems 23s or 28s-f show iner must be notified at Funeral Director	Md. Anne Aru	undel	Baltin	nore					1 Yes 2 No	
be notified Director	10e. Street and Number			10f, Zip Code		1	0g. Citizen of V	Vhat Count	rv?	
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era	11. Marital Status	12. Wes Decedent Ever in	U.S. 1			Specify Yes or No-		e - America	an Indian,	
Funer must	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cu	iban, Mexican, Pue	rto Rican, etc.)	Blac	ck, White, e	itc.	
by	3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates: 1 Q €	51-65	1□ Yes 2♥N	o Specify:		Specify	" Wh	ite	
	15. Decedent's Ed	ucation	16a. De	cedent's Usual Occ	upation		16b. Kind of Bu			
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To B	John Joseph Muel	ler.Sr.			Kath	nerine E.	Mitche	11		
-	19e. Informant's Name/Relationship (T		19b. Ma	ailing Address (Stre		Rural Route Number			Code)	
49	Dottorinin Marcillan	/ 1126.	405	C = d = 11 d	11 D 4 F	. 7 +	МТ		1005	
othe	Patricia Mueller 20a. Wethod of Disposition	(WITE)	Place of Dis	sposition (Name of	TI KOAQ I	altimore.	20c. Location	City or Tov	Mn, State	
, or	1 Burial 2 Cremetion 3 1 4 Donation 5 Other (Specify	removal from State								
injury e.	21. Signature of Funeral Service Company	- CI						SVIII	e,Marylan	
any injury	21. Olgitalare 4 1 aries at 001 14	n 11.	1	McCully-P	olyniak I	Funeral Ho	ome			
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Completed						24a. Was a perform		eva	re autopsy findings illable prior to	
Comple							/	of o	npletion of cause leeth?	
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Be	25. Was case referred to medical				26. Place of D	eath (Check only on	10)	1		
0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Outpa	tient 31 DOA	Other: 4 Nursing	Home 5 ☐ Reside	ence 6 Oth	er (Specify)	
99	27. Manner Death	28a. Dete of Injury (Month, Day Year)	28b. Time	e of 28c. In	-	28d. Describe ho				
cation	1 ☑Naturel 5 ☐ Pending investigation	(MOIIII, Day 19al)	Injur		Yes 2 No					
Certification:	3 Suicide 6 Could not be	28e. Plece of Injury - At		street, factory, offic	e	28f. Location (St	treet and Numb	er or Rural	Route Number,	
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Medical Certifi	(Check only 2 Medical Exami	Iner: On the basis of examl and manner stated.	ate and place,	end due to	the cause(s)					
Me	29b. Signature and title of certifier	MEMBER 1		29c. Lice	nse number	2	9d. Date signe	d (Month, L	Day, Year)	
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X	20 Name and address of account			~ (
1	30. Name and eddress of person who c	AN E T	em 23a) (Tyr	o L	timere	MD.	21720			
	21 Date filed (Month Day Vent)	TO PORT OF		C. 1,00.1	1100 1014	V-0				
State	31. Date filed (Month, Day, Year)	32 Regularar's Sig	Annala 00							

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Januam 30 8:45 PM **Physician** Mary McClellan /Medical 4b, City, Town, or Location of Deeth County of Death 4e Fecility Name (If not institution, give street end number Examiner ren bi HOSDI runde Ta unde Birthplece (Stete or Foreign Country) 5. Sociel Security Number 6 Sex 7. Age (In yrs lest birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Deys Months Hours Min 1□M 2MF Yrs. 069-16-3409 Director 74 Sept. 5,1923 New York Usuei Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City LlmIts 1 Yes 2 No Delaware Frankford Directo Sussex 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò Norms 23s Rt. 1 Box HA 118 Hidden Acres 19945 U.S.A. 14. Race - American Indian, Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Detes: Specify: Spanish Yes 2 No "natural", or þ 3 Widowed 4 □ Divorced White er then "nature. Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Pa. Dept. of Trans. 7 is marked other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Pages 1 and 2 should be Merital Alfred DeStella. Mary A. Reese 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) centiment of Health important: if Item 27 is any injury or other 2058. Wm. Scott Purdy (Son) 7866 Mansion House Crossing Pasadena, Md. 21122 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State Greenmount Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 2/3/98 Baltimore, Maryland 22. Name end Address of Fecility
McCully-Polyniak Funeral Home 21. Signeture of Funeral Service Licensee 3204 Mountain Road Pasadena, Maryland 21122 no 7 Approximate Intervel Between Onset and Death 23a. Part Lenter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, about, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner CONGESTIVE Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) physician an Division of Vital Records. P.O. Box 68760. be ed Physician/Medicai Due to (or es e consequence of). The law requires that the death certificete 98 ettending p signed by the e 23b. Did tobacco use contribute to the cause of peath? Part II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown py 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? should should Completed 24a. Wes en eutopsy this certificate he ral director, page 1 ☐ Yes 2 Z No No 1 Yes or Attending Physician: Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes, 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner as steted.

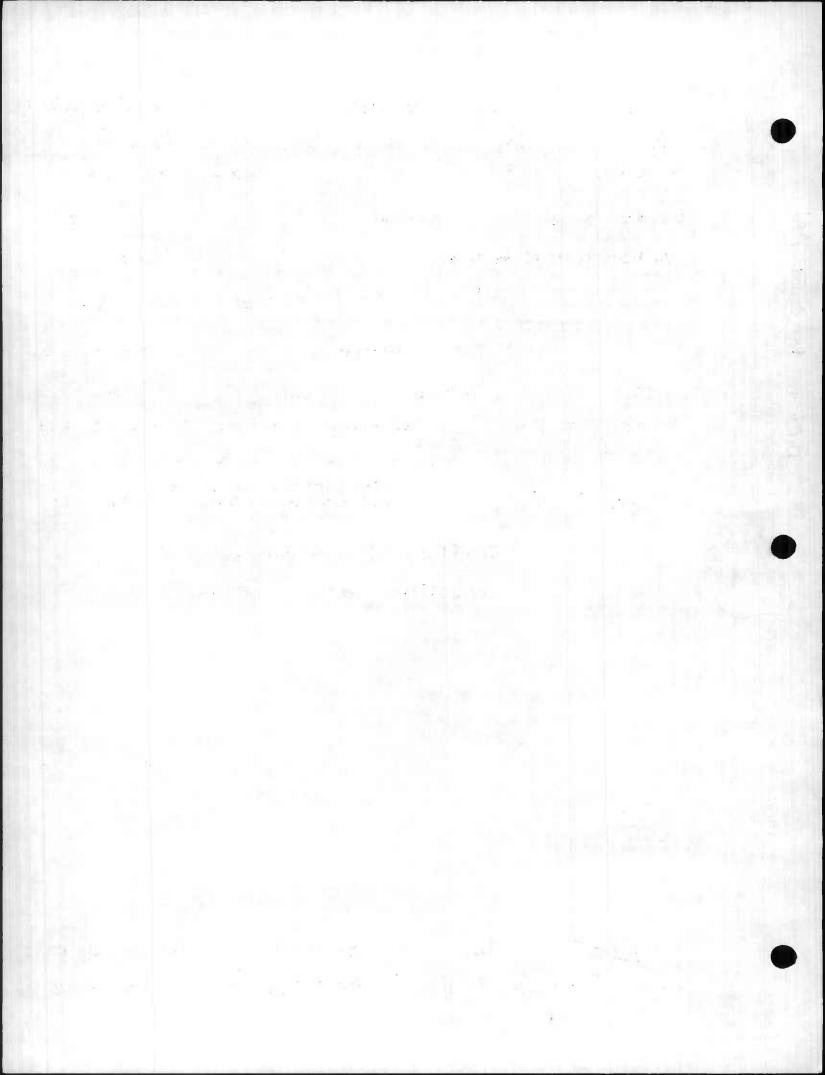
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29a. Certifier edicai (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Mis eddress of person who completed cause of death (tem 23a) (Type Print) CMOKEN meru

Registrer's Signeture

Alie Bridger

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 2 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 3:05 AM McCurdy Jan Havold 4a. Fecllity Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth City Baltimore University Manyland Hospital N/Aif Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ★M 2 F 211-24-9141 64 NOV 19, 1933 Pennsylvania Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1608 Cedar Road 20685 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Horticultural Elamantary/Secondary (0-12) Collaga (1-4or 5+) Distribution Manager Training 4 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Surname) Lloyd McCurdy Ruth Frye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Agnes F. M. McCurdy/Wife 1608 Cedar Road St. Leonard, MD 206 Date 20c. Location - City or Town, State 20685 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Mathod of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) 01/31/98 Baltimore, MD Metro Crematory, Inc. 21. Signature of Funeral Service License 22. Name end Address of Fecility Leval S. Cremation Society of MD, Inc. Edward A. Gregorchik 299 Frederick Rd Baltimore, Approximate Shock, or heart failure. List only one cause on each line. MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final . Ischemic Cardiomyopathi disease or condition rasulting In death) Sequentially list conditions, if eny, leading to immediate ceusa. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as e consequance of): Due to (or es a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Kenal Failur 24a. Wes en eutopsy performed? 24b. Were autopsy findings aveilable prior to Diabetes Mellitus completion of cause of death? 2 No 1 ☐ Yes 20 No

Physician /Medical Examiner

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To the Hospital o within 24 hours af To the Funeral Di complately filled in

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Records, P.O. Box 68760.

Division of Vital

Physician

/Medical

Examiner

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MD

Funeral

Director

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permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If filem 27 is marked other tru
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Director

Funeral

by

the Maryland

death

altimore, Maryland 21215-0020

Examiner Physician/Medical

29a. Certifier

burial-transit physician s the burial attending p signed by t Completed Be 2 funeral Certification:

25. Was cese rafarrad to medical axaminer? 1 ☐ Yes 2 No 27. Mannar of Daath

5 Panding Investigation 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be datarmined

28b. Time of

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpetient 3 DOA

26. Placa of Death (Chack only ona)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Dascriba how injury occurred 28c. Injury et Work?

1 ☐ Yas 2 ☐ No

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

Certifying Phyaician: To tha best of my knowledga, daath occurred at the tima, data and place, and dua to tha causa(s) end menner es stetad.

2 Medical Examinar: On the basis of examinetion and/or invastigation, in my opinion, death occurred at tha time, deta end place, and due to the ceuse(s) and manner stated. 29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year) Jan 29, 1998

30. Name and address of person who completed causa of death (Itam 23a) (Type, Print)

Jennifer 31. Dete filed (Month, Day, Year)

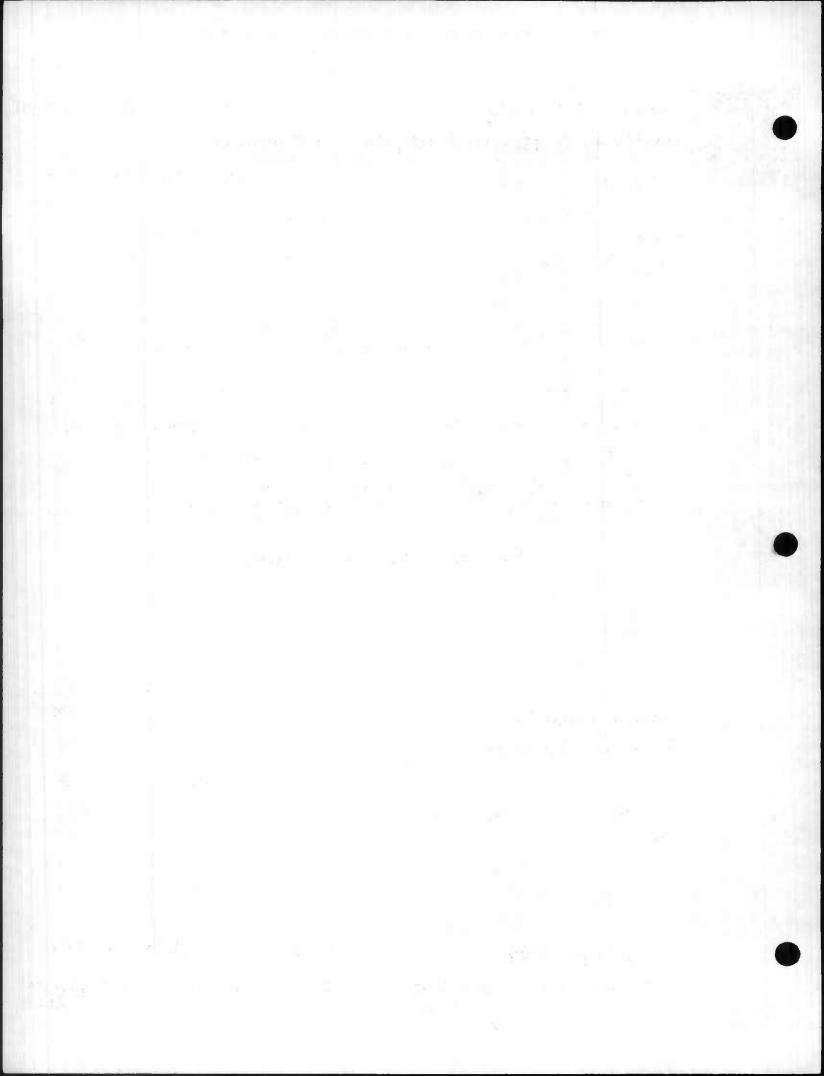
22 32. Registrar's Signature

Andrew

Andrew

S. Greene Street Baltmore, Manyland 2120

State Registrar



State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, Le	ist)	^	Jerunca	ile OI	Death	2. Dete of De	Reg. No.		3. Time of Death	
Physicia		GORTA		M	WITN	5		Month,	Day	Year 98	9:100m	
/Medic Examin	- 1	4a. Facility Name (If not institution, give	re street and number) /	1	N. P.		4b. City, Town, 9	Location of Deal	h 4c. Count		1.1-71	
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netural, or items 23a or 28a-1 show		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town	or Location			_			Od. Inside City Limits	
oh a	20	MD. NA		Balti							X Yes 2 □ No	
288	Director	10e. Street end Number		Julei		Zip Code			10g. Citizen of	What Count	in/?	
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ms 2	Funeral	11. Marital Status	12. Was Decedent Ever				Hispanic Origin? (an, Mexican, Pue	Specify Yes or No	The same of the sa	14. Race - American Indian,		
0 1	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			ecity Cub	an, Mexican, Pue Specify:	erto Rican, etc.) Black, V Specify:			ack	
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	10	William I	Mullins				Sara	n		Ben	son	
E S		19a, Informant's Name/Relationship (Type, Print)	19b.	Mailing Addre	ss (Street	end Number or F	Ru <i>rel Rou</i> te Numb	er, City or Town	, State, Zip	Code) 21223	
W -			enson	19	10 W.	Sar	atoga :					
20		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Themoval Irom Stata	cemetery	Disposition (A cremetory o	r other ple	ce)	Date	20c. Location	- City or Tov	wn, State	
ortant: fnjury 8.		4 Donation 5 Other (Special		Balt			etery (02-02-9	8 Ba	ltim	ore, Md.	
Important: Il any fnjury o		21. Sign man pf Funeral Service Lice	Dans	,							nd 21202	
		23a Parta Enter the disease, or com- shock, or heart future. List only	plications that caused the	deeth. Do no	ot enter the m	ode of dyi	rch FH ng, such as cardia	ac or respiratory	rrest,		Approximate Intervel Between	
/sician ledicai aminer	er	Immediate Cause (Final disease or condition resulting in death) a. PREUMONIA Due to (or as a consequence of):										
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page	Completed							1 🗆	Yes 2 No	1 🗆	Yes 2 No	
ertific	Be	25. Was case referred to medical examiner?						eath (Check only	one)			
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of the	Ö	27. Manner of Death S ☐ Pending	28a. Dete of Injury (Month, Dey Yea	7) 28b. Tir	ury	28c. Inju Wo		28d. Describe	how injury occur	rred		
oy the	Certification:	2 Accident Investigation 3 Sulcide 6 Could not b	Α	N. 1. 2. 2. 4. 2. 2.	M		Yes 2 □ No	Opt Leasting	Chant and Non	has as Burni	Contact them to a	
Direct in by		4 ☐ Homicide determined	28e. Placa of Injury - A building, etc. (Sp	ecify)	n, street, racti	ory, office			Street end Num wn, Stete)	oer or Hurai	Houte Number,	
		29a. Certifier Certifying Ph	ysiclen: To the best of my	knowledge.	death occurre	d at the ti	me, date and plac	a. and due to the	cause(s) and m	enner as ste	ated	
Participation of the participa	edical	(Check only and Medical Examone)	niner: On the basis of exam and manner stated.	nination and/	or Investigation	on, in my	pinlon, death occ	urred at the time,	date and place,	and due to	the cause(s)	
	-	29b. Signature and the of certifier	0 1		2	9c. Licens	se number		29d. Date signe	ed (Month, E	Dey, Yeer)	
Section 1		> 1 dichollo	- led mA	Nn	17	PII	775		JAN.	28	1998	
	-	30. Name and address of person who	completed cause of death	Item 23a) (T	ype, Print)	1-	11	.1	4	- 1	`	
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DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** Mary Keysor Meyer 29 Janya /Medical 4e Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner runde, Hospita Hrun de Durnie If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (Inlyrs. lest birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** Deys Hours 1□ M 2□ F Yrs. 067-18-5404 78 Director 20, 1919 Ohio Usuet Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Carrol1 Mt. Airy 10e. Street end Number 10f Zip Code 10g. Citizen of Whet Country? 5179 Perry Road 21771 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White p 3☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry Genealogical Elementary/Secondery (0-12) 12 College (1-4or 5+) Author Publications 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) William C. Keysor Grace Allen 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melting Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Steven K. Meyer/son 5178 Perry Rd. Mt. Airy MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 21771 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Metro Crematory, Inc. 01/31/98 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signeture of Puperal Service License 22. Name and Address of Fecility Cremation Society of Maryland, Inc. Edward A. Gragorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of). 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown P 24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 24e. Wes en eutopsy performed? Completed 25. Wes cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 Yes 2 No spital: 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of injury (Month, Dey Year) 28b. Time of injury (Injury) 28c. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Deeth 1 Neturei 2 ☐ Accident Certification: 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

that the death certificate be axecuted Division of Vital Records, P.O. Box 68760,

Peges 1 end 2 should be filed within 72 hours efter death with the Manyland nent of Hauth end Mental Hygiena. ntt: If Item 27 ie marked other than "natural", or items 23a or 28a-1 show ntt: If Item 27 ie marked other than "natural", or other traumatic event, the Medical Examine mainten notified at any or other traumatic event, the Medical Examine

important: If it eny injury or c

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attending ph

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funeral director, After this death. after death Director: filled in 24 hours a Hospital To the F within 2

Registrar

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29a. Certifier

(Check only one)

29b. Signature and title of certifier

FEB

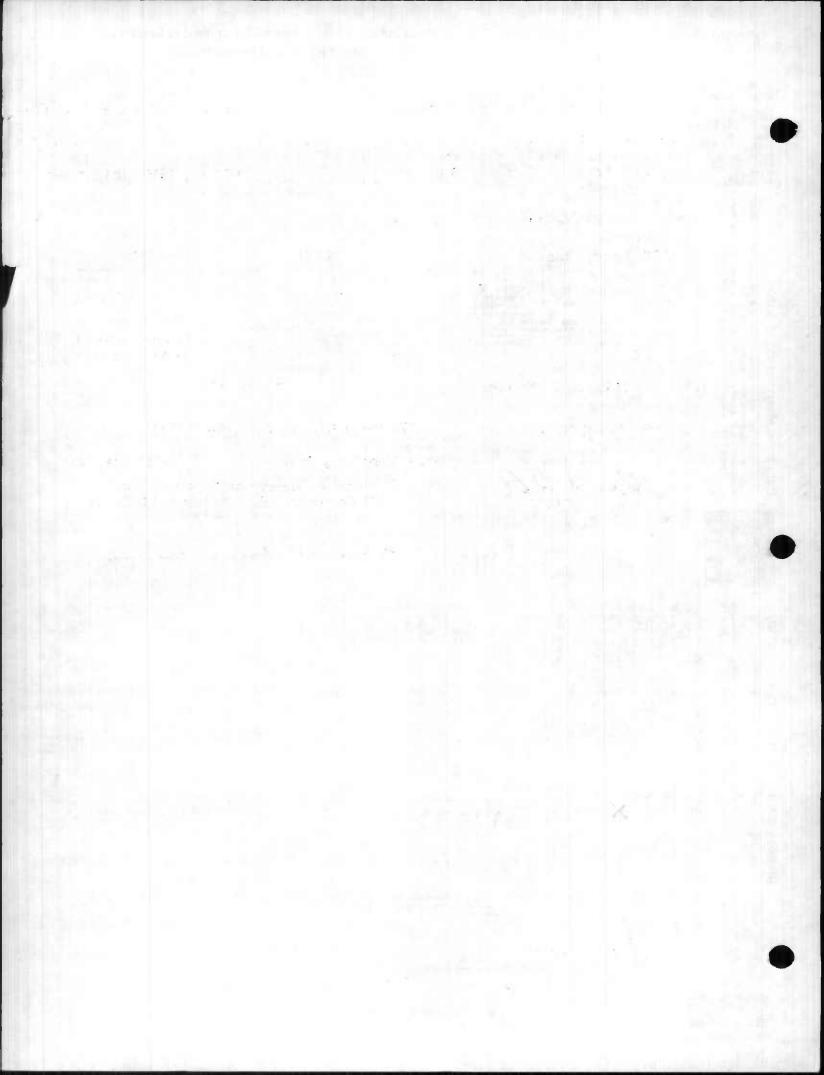
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12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piace, end due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted. 29d. Date signed (Month, Dey, Year)

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

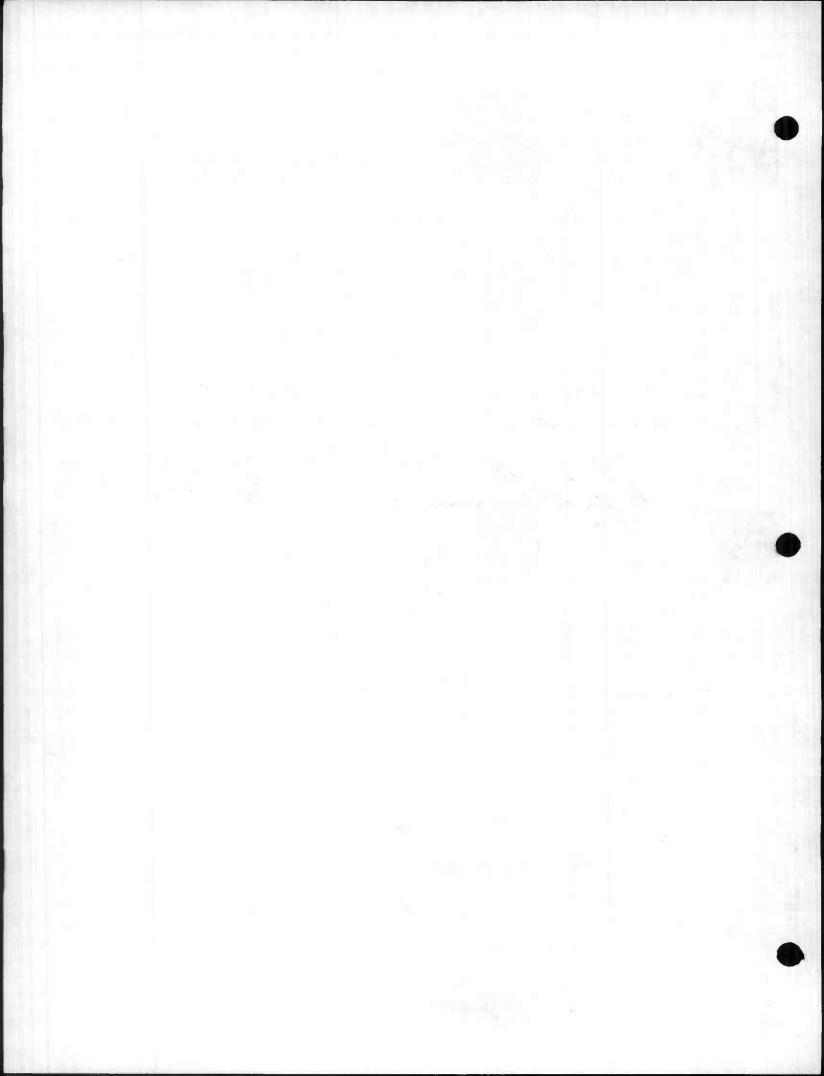
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State of Maryland / Department of Health and Mental Hygiene

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Funeral Director			Sex 1□M 2XIF	7. Age (In yrs. 79	last birthday) Yrs.	if Under 1 Months	Year if Un Deys Hou	der 24 Hrs. Irs Min.	8. Dete of Bi (Month, Di AUG. 5	irth ay, Year) 5, 1918		ca (State or sy)			
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or 28a-f show	Director	TENNESSEE KNOX		F	NOXVIL	LE						1 ☐ Yes 2			
3e or 2		10e. Street end Number 3505 LANSING AVEN	UE			10f. Zip C		914		10g. Citizen of U.S		y?			
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F & 5	al Director: After tied in by the funeral Certification:	3 Sulcide 6 Could not b	28e. Plece	Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)					281. Location (Street end Number or Rural Route N City or Town, Stete)			Route Number			
urs efter death. ral Director: Af illed in by the fu	Certific	4 Homicide determined			29a. Certifier (Check only 20 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 29a. Certifier (Check only 20 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s)										
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within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	Medicai Certific	29a. Certifier (Check only one) 29b. Signeture end title of cartifier	nysician: To the miner: On the b end men	asis of examina ner stated.	owledge, death	vestigation, ir	i my opinion, icense numb	death occu	rred et the time	, dete end place, 29d. Dete signe	end due to t	the ceuse(s)			
4 hours efter deat Funeral Director: tely filled in by the	edicai	29a. Certifier 12 Certifying Processing one) 2 Medical Example 12 Medi	nysician: To the miner: On the bend men	asis of examination of stated.	ation end/or in	29c. I	imy opinion, icense numb	death occu	rred et the time	, dete end place, 29d. Dete signe	end due to to ded (Month, D	ay, Year)			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28 **Physician** 1998 5:00 Am an /Medical Balti 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) Examiner 2309 012 Maple Ellicott Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Dey. Y timore 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 10M 2□ F Months 213-14-9676 7 Yrs. **Director** Usual Residence of Decedent the Marylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show Baltimore Ellicott 1 Yes 2 HO Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with in than "natural", or items 23a or old maple Court 21042 AZU 2309 Funeral 12. Was Decedent Ever in U.S. Armed Ecross? 1 Ness 2 No 3 13-43 If Yes, Give Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 2.2.46 Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. DESIGNER Commercia ! 12th I is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health end Mental Int: If Item 27 is marked of Morthern Harvey NELSON 1010 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Helationship (Type, Pnnt) GOnard Cornish - N 2309 Old Maple Ct. Ellicott City Md 21042 20b. Place of Disposition (Name of cametery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State = 0 Garrison 2.2.98 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Funerel Service Licensee , wes Avenue MI wabast ter the chease, or complications that caused the death. Do not enter heart talke. List only one ceuse on each line. the mode of dying, such as cerdiac or respiratory arrest, **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner 2 years physician and s the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieled events resulting in deeth) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, certificate be Physician/Medical Due to (or as a consequance of): 40 attending p signed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed is certificate has director, page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural efter death. 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) à 4 Homicide 24 hours efter Funeral Dire letely filled in b ò 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated. 29e. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 1)19823

State Registrar

gistrar FEB 0 2 1998

30. Name end address of person who completed cause

BOONYONG

31. Date filed (Month, Day, Year)

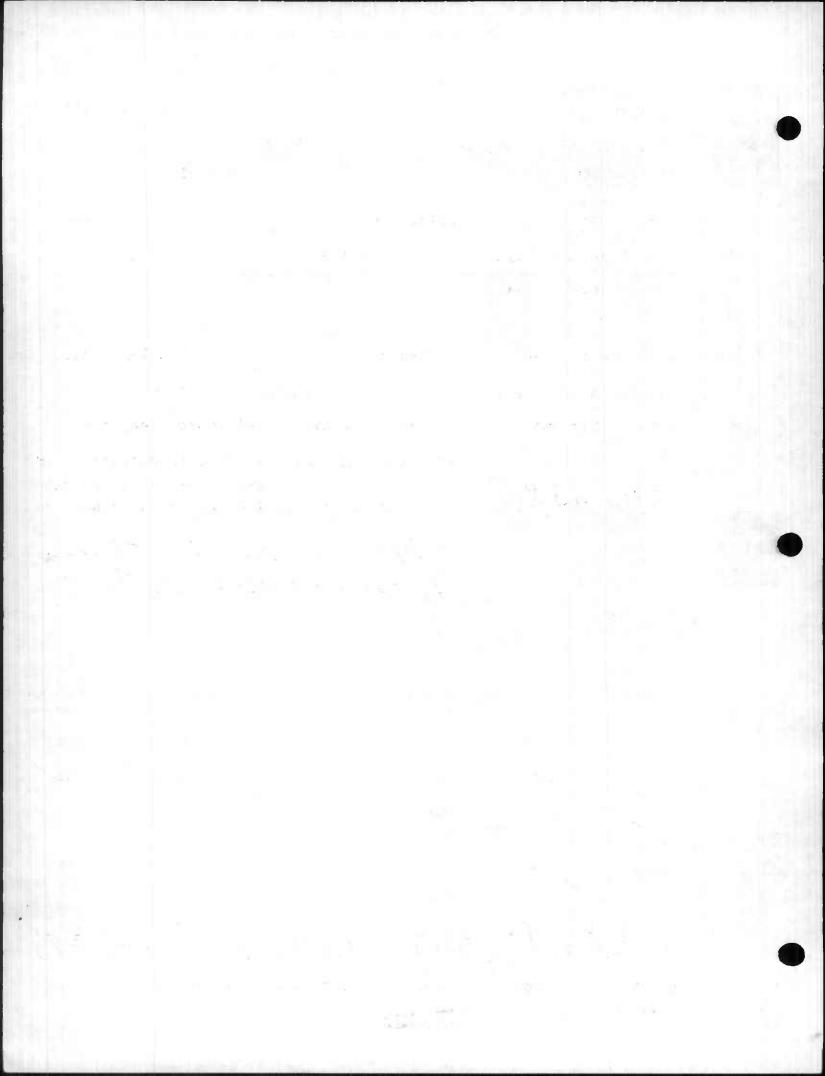
32. Redistrar's Signature

of death (Item 23e) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 8 0 2 6 0 7

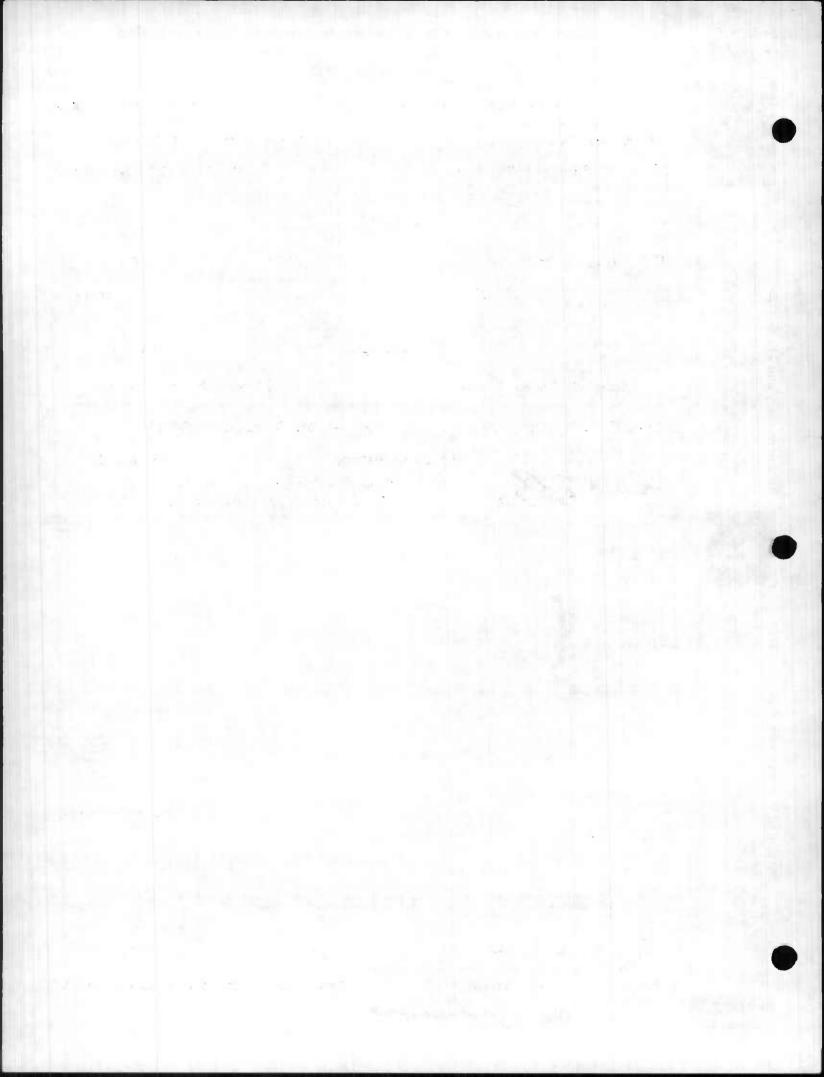
					Certific	ate of	Death		Reg. No.	UZ	1001			
B		1. Decedent's Neme (First, Middle, L	ast)	1 5 4 1				2. Dete of De	ath	Vaca	3. Time of De			
Physici /Medic		Robert	Theodor	e Ne	al			Jan.	25,	98	19:15			
Examin		4e. Fecility Neme (If not Institution, g					4b. City, Town,	or Location of Deet	4c. Count	ty of Deeth				
		Good Samarit	an Hospi	tal			Baltin	more	N/	Δ				
Funeral				ge (in yrs. last bi		der 1 Yea	If Under 24 h			9. Birthple	ece (Stete or F			
Director		219-32-7300	1½ M 2□ F	59	Yrs. Mont	hs Deys	Hours N	Irs. 8. Date of Bir Month, Da 02-13	y, reer) -38	Count				
		Usual Residence of Decedent			110	•								
show		10a. State 10b. County		10c. City, Tov	n or Location					10	d. Inside City L			
13	to	MD. NA		Balt	imore						XXYes 2			
128	Director	10e. Street end Number			10f.	Zip Code			10g. Citizen of	Whet Count	iry?			
natural, or items 23a or 28a-f show dical Examiner must be notified at	0	1237 Sheridar	Avenue			2123	9		US	SA				
al', or items 23a or 28a-f show Examiner must be notified at	Funeral	11. Maritel Stetus	12. Was Decedent	Ever in U,S.	13. Was De	cedent of	Hispenic Origin?	(Specify Yes or No lerto Rican, etc.)	- 14. Ra	ce - Americe				
4.5		1 ☐ Never Married 2€ Married	Armed Forces					erto Rican, etc.)	Ble	eck, White, e				
P. C.	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:		1 ☐ Yes	s 2⊠ No	Specify:		Speci	by: B1	ack			
"natural",	P	15. Decedent's E	Educetion	16e	. Decedent's U	Isuel Occu	petion		16b. Kind of E	Business/Ind	ustry			
- 20	Completed	(Specify only highest g.		5.1	(Give kind of life. DO NO	work done T use retin	during most of (working						
Hygiene. ther than int, the M	E	10th Grade	College (1-4or		abor				Beth!	lehem	Steel			
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0 0	To B	Alphonso	Neal				Aman	la Smith						
n end Menta 7 is marked traumatic e	1	19a. Informent's Name/Relationship		19	Mailing Addr	ass (Strag		Rural Route Numbe			Code) -			
7 is trau											212			
Item 27 other tr		Lisa Freen 20a. Method of Disposition	lali					BAltimo		_				
- h		1 Burial 2 Cremetion 3	☐Removal from State											
tant		20a. Method of Disposition 1												
Department Important: If any injury o once.		> (Nue of		2						_				
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ololon		23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Shock, or heart feiture. List only one cause on each line. Approximate Interval Beh Onset end I												
nysician Medical														
xaminer		disease or condition resulting in deeth)	θ	my 6	Car	1 ch	1000							
	-			Due to (or es e	consequence	of):	A 47 6	-Ao-	Ma	007	11			
ısıt	in in		b	1)	W		11000	and I	1318	en	10.			
physician end s the buriel-trensit	Examiner	Sequentielly list conditions, Due to (or es e consequence of): if eny, leading to Immediate ceuse. Enter Underlying												
cian		ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events												
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tend or us	an/													
ed fo	Physician/	Pert tl. Other eignificant conditions	23b. Dld	tobacco uee ce	ontribute to	the cause of d								
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gned be de	by													
O D								24a. Wes	en eutopsy	24b. Wei	re eutopsy find			
shoul	Completed							_ perio	rmed?	con	illeble prior to apletion of ceus leath?			
ete hes page 2	Ĕ		_											
lcete		or W /						10'	res 2 40	1 1 1	Yes 20-No			
director, pag	Be	25. Was cese referred to munical examiner?	Hospital:			0		Deeth (Check only o	ne)					
9 9	2	1 Yes 2	1 Linpatio		-	DOA		g Home 5 Resid)			
Atter th funeral	Certification:	27. Menner of Deeth 1 ☑ Maturel 5 ☐ Pending	28e. Dete of Inju (Month, De		Time of Injury	28c. Inju	iry et ork?	28d. Describe	now Injury occu	rred				
the ft	ati	2 Accident investigation			М	10	Yes 2□No							
i.	Ĕ	3 Suicide 6 Could not 9	286. Piece of in	jury - At home, fa c. (Specify)	arm, street, fac	tory, office		28f. Location (: City or Tox	Street end Num	ber or Rural	Route Number			
	Se l	/	Dunding, or	o. (opecity)				0.19 07 70.	,,, 0.010)					
To the Funeral		29a. Certifier 1 Certifying P	hysicien: To the best	of my knowledge	e, death occurr	ed et the t	ime, dete end ple	ece, end due to the	ceuse(s) end m	enner es ste	eted.			
Fig.	edicai	(Check only 2 Medical Exa	mtner: On the besis o end menner st	f examinetion er eted.	d/or Investiget	ion, In my	opinion, death or	courred et the time,	date end place	, end due to	the ceuse(s)			
To the	X	29b. Signeture entit little of certifier	0.	Λ		29c. Licen	se nu <i>m</i> ber		29d. Dete sign	ed (Month, E	Dey, Yeer)			
> - 0		1 4/10	U.	(1)	-	1	na	CQ		1-7	9-9			
	1	Ma	Mr.	VV4)		1	YTO.	20	(1 1			
		30. Neme end eddress of person who					1							
		Dr. Kiumarce	Kashi, M	D 9506	Harf	ord 1	Road Ba	altimore	, Mary	yland	21234			
Stat	te	31. Dete filed (Month, Dey, Year)	32 Registr	ar's Signeture										



98-0451-033

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

KELLY NALWASKY I	tems:23a part I,	27 per ME	State of Ma 0 G-756 2/1		•			vientai Hy	Reg. No. 9	026	08	
Physician /Medical	1. Decedent's Neme (Firs	st, Middle, Last)	y Elizal					2. Dete of De Month JANUAR	Dey	Yeer	ime of Deeth	
Examiner	4e Fecility Neme (If not in 8118 LAPLAT		treet and number)				4b. City, Town, or L COLLEGE				S	
Funeral Director	5. Sociel Security Numbe 214-17-97		M 25 F 7. Age	(In yrs. les	Yrs. If Un	der 1 Year hs Deys	If Under 24 Hrs. Hours Min.	8. Date of Bi Month, Di JAN 22	rth ey, Year) 1978	9. Birthplece (Country) Maryla	State or Foreign	
death with the Maryland ms 23e or 28s-f show rmst to nortified at neral Director	and the same of th	County		10c. City, 7	Town or Location						side City Limits	
vith the Maryla or 28a-f shore be notfied at	MD	N/A]	Baltimo	re					Yes 2 No	
or 2	10e. Street end Number				10f.	Zip Code			10g. Citizen of V	Whet Country?		
ath w	3919 Juni	per Ro	ad				21218		US	A	0-5	
UZO urs after br. or its Everation	3 ☐ Widowed 4 ☐ □	2 Married	2. Wes Decedent E Armed Forces? 1 Yes 25 No If Yes, Give Yeer or Dates:			specify Cub	dispenic Origin? (S) en, Mexican, Puert Specify:	pecify Yes or No p Rican, etc.)	Bled	ck, White, etc.		
	15. Elementary/Secondery	Decedent's Educ by highest grade (0-12)		-)	16e. Decedent's U (Give kind of life. DO NO Stude		pation during most of wor d)	king	alion of Death ARK PRINCE GEORGES B. Date of Birth Marylan 10d. Inside 12 Your Specify: White, etc. Specify: White 16b. Kind of Business/Industry College (First, Middle, Maiden Sumeme) abeth Ann Pope (Foute Number, City or Town, Stete, Zip Code) More, MD 21218 Dete 20c. Location - City or Town, Stete O/98 Baltimore, MD of Maryland, Inc. Baltimore, MD 21228 respiretory errest, Approxim Intervel if Onset er 23b. Did tobacco use contribute to the cause of the completion of deeth?			
Hygie Hygie ont,		Middle, Last)	1		blude	111	18. Mother's Nan	ne (First, Middle				
Maryland 2127 to 2 should be filed within th and Mantal Hygiena. 77 Is marked other than To Be Compl	D: 1.		nes Nalw	asky			Eli	lizabeth Ann Pope				
2 should and Mismeria	19a. Informent's Name/R	leletionship (Typ	pe, Print)		19b. Meiling Addr	ress (Street	1			-)	
Baltimore, Maryland permit. Pages 1 and 2 should be filed Department of Health and Mantal Hyg important: If Itan 27 is marked other any injury or other traumatic event, once. To Be C	Elizabeth A	n		20b. Pled	3919 Junte of Disposition (Neme of		imore,	MD 21218	City or Town, S	tete	
Page Page int: If	1 Burial 2 X Cre 4 Donation 5 C		emovel from Stele				Inc. 01/	30/98	Baltimo	re, MD		
Balting permit. Pa Departman Important: any injury once.	21. Signeture of Funeral Edward A	t. Kil	rchik		22 Name Crem 299	end Address	Society rick Rd.	of Mary Baltim	yland, I ore, MD	nc. 21228		
	23a. Part1. Enter the dis- shock, or heart failu	ease, or complicate. List only one	ations thet caused to	he deeth.						Appr	oximete vel Between	
BOX 68 / 60, ath cartificate be axecuted attending physician and cor use as the burial-transit about the correct corre	Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest	e. s, ete c. d.	C	Due to (or e	(ASTROCYTO s e consequence s e consequence s e consequenca	of): of):						
aath cartif attanding I for usa a	Seattle Other stands and	det	officially and a second second form	one to Don't								
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IN RECORDS, F The law requires that the been signed page 2 should be del Completed by P								24a. We	s en eutopsy formed?	eveileble	prior to	
T a - 6 5								10	Yes 2 No	1 Yes	2□ No	
r VItal I ysiclen: The s cartificata director, pag		medical					26. Place of Dec	oth (Check only	one)			
Ing Phys Ing Phys Attar this funaral di	1⊠ Yes 2□ No	Pending investigation	28e. Dete of Injury (Month, Dey		Bb. Time of Injury	28c. Inju	her: 4 Nursing H ry et rk?] Yes 2 No				RMITORY	
	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Plece of inju- building, etc.	ry - At home (Specify)	e, ferm, street, fac	ctory, offica				ber or Rural Rou	fe Number,	
To the Hospital or within 24 hours afte To the Funeral Dir completally filled in Medical Cert	29a. Certifier 1 (Check only 2X) III		cian: To the best of er: On the besis of and manner stat	exeminetion							cause(s)	
To the company	29b. Signature end title o	f cartifier				29c. Licen	se number		29d. Dete signe	d (Month, Dey,	Year)	
	Name end eddress of	person who cor	mpleted cause of de	eth (Item 2	3e) (Type, Print)	0.C.	M.E.	1	JANUARY	29,1998		
	31. Dete filed (Month, De	DA.K	ORoll un	re Rimontos	11	1 Per	n Street	, Balti	more, Ma	ryland	21201	
State Registrar	FFR (2 1998	Foliar	avidsor	-Mandelle							

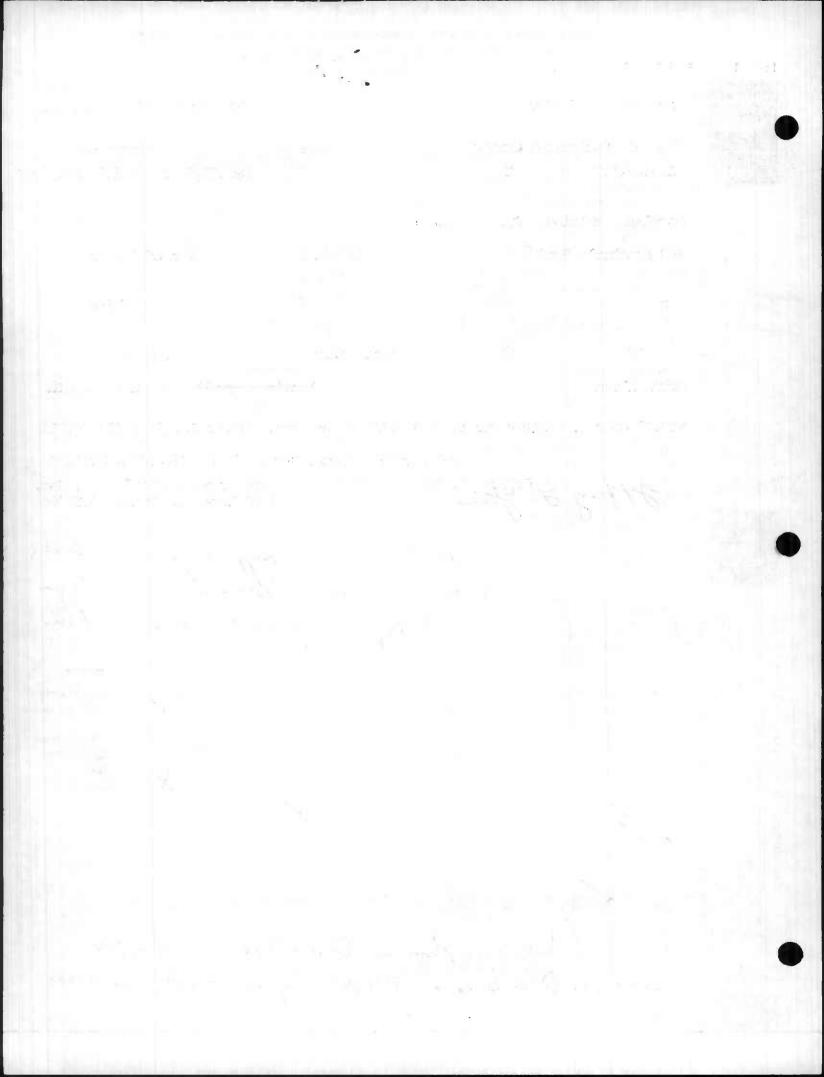


State of Maryland / Department of Health and Mental Hygiene Item: 18 Per FH Film G-756 2-2-98RC Certificate of Death 1. Dacedant's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 30, 1998 Mary Wilson Pfeifer January 3:00 AM /Medical 4b. City, Town, or Location of Deeth 4a. Fecility Name (If not institution, giva street and number) 4c. County of Death Examiner Towson
If Undar 24 Hrs.
Hours Min.

8. Data of Birth
(Month, Day Year)
Dec. 31, 1903 Edenwald Retirement Center Baltimore Co.

9. Birthplace (Steta or Foreign Country)
Oriole, Maryland If Under 1 Year 7. Aga (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2 F 215-48-1117 94 Yrs. Director Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No r 28a-f Directo Maryland Baltimore Co. Towson 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Herna 23a or the Medical Examiner must be 800 Southerly Road 21286-8403 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ②No If Yas, Giva Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 *natural", or 1 ☐ Yes 2 X No Specify: Specify: b White 3 ₩ Widowed 4 Divorced Completed Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry filed within 7 Hyglene. Than Elamentery/Secondary (0-12) College (1-4or 5+) 01 Home Maker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be 2 should be and Mental marked John Wilson Mattie Croswell MARTHA ELBERT CROSWELL 2 Department of Health and Important: If Hem 27 is me any Injury or 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Mrs. Eleanor D. Pfeifer (Dau. In Law) 1119 Cowpens Ave. Towson, Maryland 21286-1719 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1X Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata Dulaney Valley Mem. Gard. 02/02/98 Timonium, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee Te frey L. 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. Gair air 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Deeth **Physician** /Medicai Immediata Ceuse (Final disaasa or condition rasulting In daath) Examiner Examiner physician and the buriel-transit Sequantially list conditions, if eny, laading to Immediate causa. Entar Underlying Cause (Diseese or Injury that initiated evants rasulting In daath) Last Box 68760 certificete be Physician/Medical Due to (or as a consequent ce of) 80 attending esn O signed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Wara autopsy tindings available prior to Completed peed : completion of cause of death? hes page 2 1 ☐ Yas 2 ☐ No certificate or Attending Physician: director, 25. Was casa rafarred to madical axaminar? Be 26. Placa of Daath (Check only ona) 1 ☐ Yas 2 No 27. Manner of Death Other: P Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3□ DOA funeral after deeth. 28a. Data of Injury (Month, Day Yaar) 28b. Time of 28c. injury at Work? 28d. Describe how Injury occurred Certification: 5 Panding 1 Naturai Invastigation 1 ☐ Yas 2 No 2 Accident 6 Could not be datermined 3 ☐ Suicida 28t. Location (Streat end Number or Rural Routa Number, City or Town, Stete) Place of Injury - At homa, farm, street, tactory, office building, etc. (Specify) 4 Homicide Hospital
 24 hours a
 Funeral D Cartifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, and due to the causa(s) and mannar es steted.

Medical Exeminer: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and plece, end due to the ceuse(s) and mannar stated. 29a. Certifier Medicai To the I within 2 To the I 29b. Signature and title of certifie 29c. Licanse number 29d. Date signad (Month, Dey, Year) person who complated causa of daath (Itam 23a) (Type, Print) Usverne horse 31. Data filad (Month, Day, Year) 32. Registrar's Signatura State which Divideon Randall Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 18 per FH G-756 2/6/98 dh 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** Month 14:44 38 /Medical 22 3 (Ab City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner R. Adams Cowlo Shock I Manna Canter More If Under 1 Year 8. Date of Birth YMonth, Dey, Y HOR 18 5. Social Security Number 6. Sex 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 F Days Hours 76 229-16-1759 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exactives must be notified as Baltimore AM 1 Nes 2 □ No Ma Director 10e. Street end Number 10f. Zip Code 10a, Citizen of Whet Country? 21215 3615 lechler MZA Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify. Blac þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) boree NA 1241 ETH 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be 1 Health and Mental I Edward MINNIE al as 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Peges 1 end 2 ment of Health e Aug Beehler Datto. Hd 21215 Wite other ITAINIA Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State ō Important: 4 ☐ Donation 5 ☐ Other (Specify) odlawi any injury 21. Signature of Funerel Service Licenses 22 Name and Address of Facility
Wm C. March Funeral march 23a. Part 1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Balto Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical Due to (or as e consequence of): be detached for use Pert II. Other eignificant conditions contributing to doubt but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? this certificata 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA funeral ate of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar 1 Netural 5 Pending investigation 2 No 1 Yes N death. 2 Accident eftar death 6 Could not be determined 28f. Location (Street a City or Town, Str 3 Suicide 28e. Place of Injury - At home, farm, street building, etc. (Specify) and Number or Rural Route Number, factory, office In by 4 Homicide 24 hours Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated. 29a. Certifier Medical pletely (Check only one) To the I within 2 29c. License numbe Cowley Greene St. (MonA, 2)

State

Registrar

31. Date filed (Month, Day, Year)

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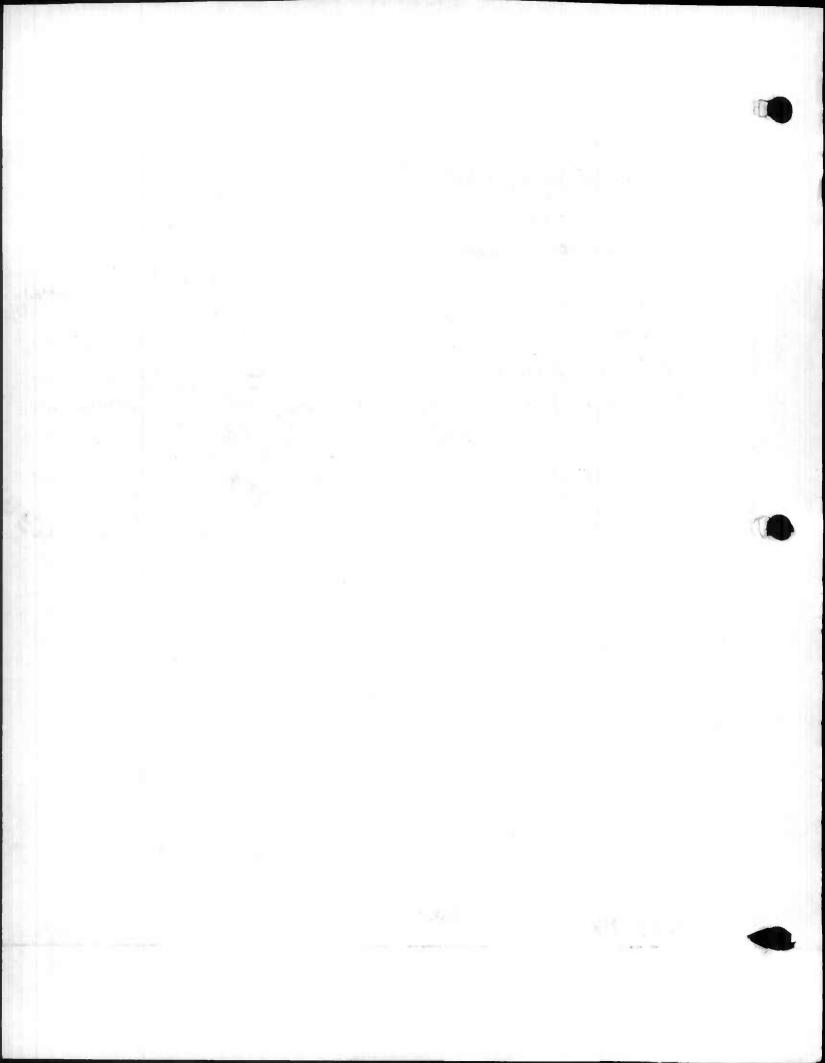
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR oh 998 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 NF FACILITY NAME (If not institution, gi -02 permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR KehAblenke 10b. COUNTY 10c. CITY, TOWN OR LOCATION mary land (0 1 YES 2 NO FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 05 as the burial-transit after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-H was anacity Cuban, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. If yes, specify Cube ORCES? 1 YES 2 NO FORCES? 1 Never Married 2 Married Specify BY 3 Widowed 4 Divorced American ED 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY use (Specify only high (Give kind of work done life. Do NOT use retired.) H /Secondary (0-12) detached for ge (1-4 or 5 +) COMPL once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle at a page 5 should be notified Mr. Ode Pe 20e. METNOD OF OISPOSITION
1 ➡ Burlet 2 □ Cremetion 3 □ Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of must the funeral director, 4 Donation 8 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart fellure. List only one cause on each line. in by Approximate interval Between 0 filled IMMEDIATE CAUSE (Finel Onset and Death the cremation. disease or condition ancer 0 completely event, 1 resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) 3 marty burial. other traumatic CERTIFICATION and Sequentially list conditions, 2 If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO JOR AS A CONSEQUENCE OF that initiated eventa reaulting in deeth) LAST 10 The atten Injury. PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s WAS AN AUTOPSY 245 WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? shows any tion 1 TYES 2 NO Prylneul-1 - YES 2 NO been t. of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗹 NO 🗌 UNCERTAIN 🗆 PHYSICIAN: has be Dept. 23 26. PLACE OF OEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL Item certificate h **EXAMINER?** OTHER: 1 TYES ZENO 1 Inputiant 2 ER/Outputiant 3 DOA ng Nome 5 - Rasidenca 8 - Other (Specify) 0 the 27. MANNER OF DEATH 28a, DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF INJURY 284 DESCRIBE NOW IN HIRY OCCURED this c marked, 1 Natural
2 Accident 1 YES 2 NO BY After 1 Investigation 3 Suicide 28a. PLACE OF INJURY — At homa, farm, streat, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 50 DIRECTOR: hours after of 4 Nomicide datarmined 28 Item COMPL 1 💢 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as stated. FUNERAL within 72 h IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion. death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 를보로 Q D1960 Jan 223 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3503 PERRY ST. MT. RAINIER, MARYLAND 20712 TULI

STRAR'S SHANTURE

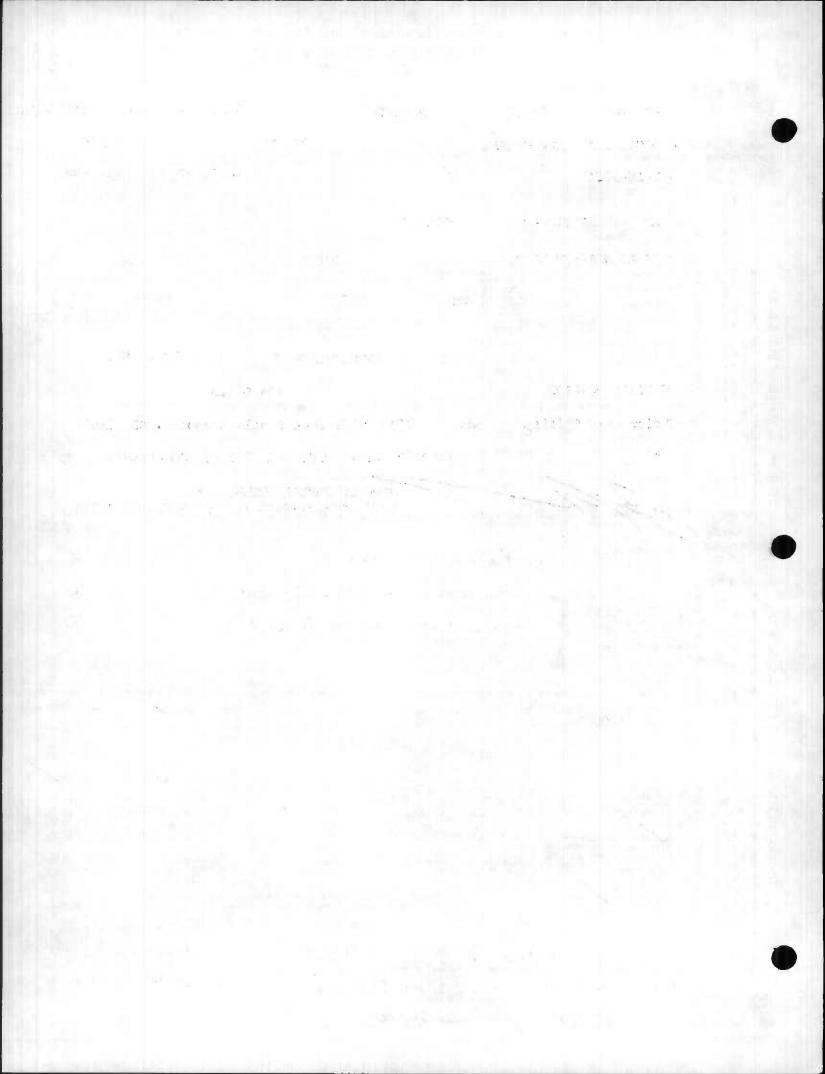
RAMAN 31. DATE FILED (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** JAN. 29 1998 4:15 A.M. ROYSTON DULIN PHILIPP /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNAPOLIS ANNE ARUNDEL GENESIS SPA CREEK CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 □ F Yrs. 75 Director 10/15/22 MARYLAND 219-18-3321 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Modical Examiner must be notified at 1 Yes 2 No Director MD BALTIMORE TOWSON 10g. Citizen of What Country? 10e. Street end Number 10f. Zlp Code with 8334 LOCH RAVEN BLVD. Funeral 21286 USA 14. Raca - American Indian, filed within 72 hours after death 12. Was Decedent Ever in U,S.
Armed Forces?
1 □X'es 2 □ No
If Yes, Give
Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: py 3 □ Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) SHIP YARD 2 YEARS SUPERINTENDENT 7 is marked other traumatic event, ii 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be sent of Health and Mental 2 WILLIAM PHILIPP IDA DULIN 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Christopher Philipp Son 1714 Robin Hood Trail Annapolis, MD 21401 or other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or DULANEY VALLEY MEM. GAR. 2/3/98 COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility JOHNSON FUNERAL HOME, P.A. 21286 Approximate Interval Between Onset end Death 8521 LOCH RAVEN BLVD. TOWSON, MD anter the mode of dying, such as cardiac or respiratory arrest. the disease, or complications that caused the deeth. Do not enti-heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final Pulmonary edema disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner 10 Schemic Carchomyopathi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequenca of): and 20 physician a s the burlai-· Atherosclerotic Heart Box 68760 2 Physician/Medical Due to (or as a consequence of 88 23b. Did tobacco use contributa to the causa of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the a Division of Vital Records, P.O. 1 Yee 22 No 3 Probably 4 Unknown signed p 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy Completed Deed After this certificate has funeral director, page 2 1 Yes 2000 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes PNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menne of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation Natural 1 Yes 2 No death. 2 Accident Director: A 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral DI completely filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number 0 January 30 1998 Barbara 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Road, Annapolis Md 21401 Forest 505, EDDing Bar bara 31. Date filed (Month, Day, Year) 32. Registrar's Signature State whe Davidson Randolle Registrar FEB 02 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1998 17:05 Catherine Louise Pear January 28. 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Atlantic General Hospital Berlin Worchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. July 5, 1906 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 1□M 2NF 91 Yrs. 219-14-1922 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7621 Turnbrook Drive 21060 USA 12, Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 No Specify: specify: White 3 M Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Household 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Nagley Ida Mae Unknown 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettie Mae Cooper/Daughter 11003-41 Grays Corner Rd., Berlin, MD 21811 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burlet 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Pk.Jan. 31 Eldridge, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth TE Myocardial Infanction

Due to (or es e consequence of):

RDIAC ARRHYThmia Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? 2 200 1 ☐ Yes 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

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by

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In and Mental Hyglena. 7 is merked other than "natural", or items 23s or 28s-f.: traumatic event, the Medical Examiner must be notified

Physician/Medical by Completed

physician and the buriai-transit attending signed by the at d be detached for funeral director, Be 2 Certification: Director To the Hospital of within 24 hours a To the Funeral D completally filled in Medicai

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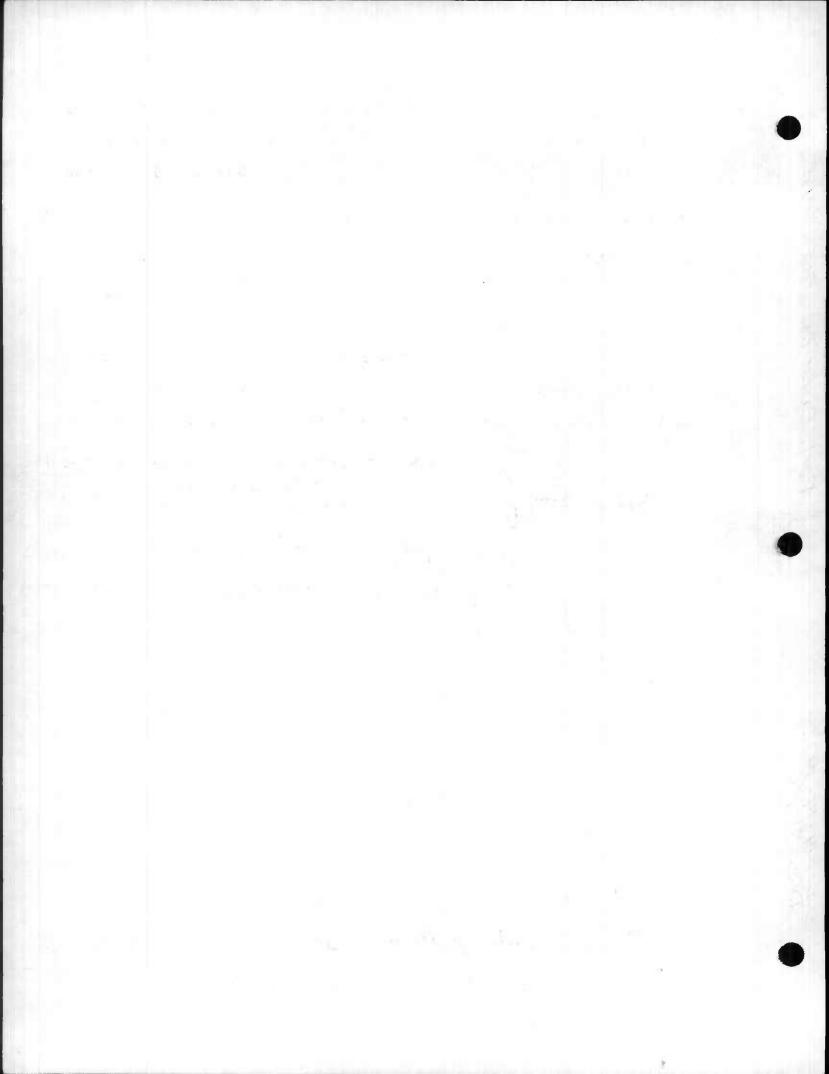
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier

Kago, M.D. eonge

29d. Date signed (Month, Dey, Year) January 28, 1998

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

George 31. Date filed (Month, Day, Year) FEB 0 2 1998 DiKago, MD Rt. 113 S., Berlin, MD 21811 Registrar's Signature



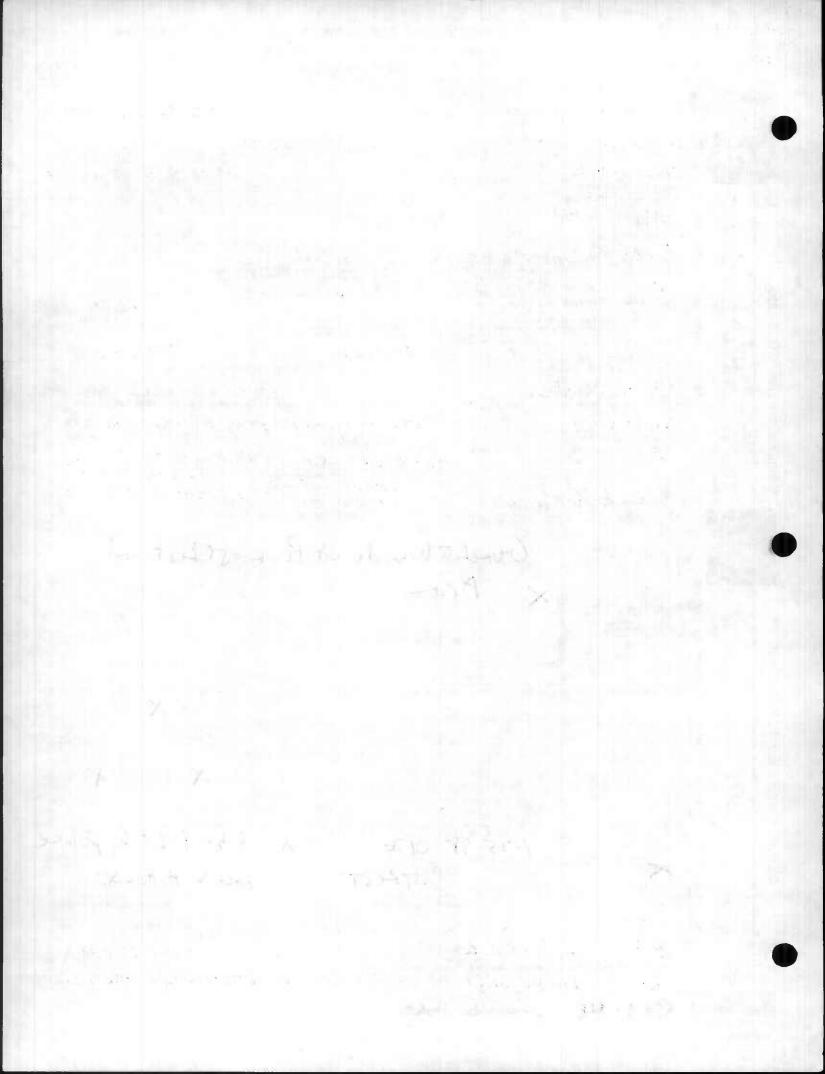
98-0399-510 98-027 CORNELUIS ROGER

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State of Maryland / Department of Health and Mental Hygiene

OR	NELUIS RO	OGERS			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cer	tificate of	Death		Reg. No.	UZ	614
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	Funeral	5. Social Security			Age (In yrs. les		If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthp	place (State or Foreign
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	72 hours effer death with the Meryland natural; or items 23a or 28a-f show old Examiner must be notified at the by Funeral Director	11. Marital Stetus	60041	12. Was Decede		13. V		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No	- 14. Rac		can Indien,
0	or iter		rried 2 Married	Armed Force			./		Rican, etc.)		ck, White,	etc.
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21215-0020	ed within 72 hours ygiene. her than "natural", ft, the Modes Ex.	(Sp	15. Decedent's ecify only highest of		1	16a. Deced	ent's Usual Occup	ation during most of work	ina	16b. Kind of B	usiness/In	dustry
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Baltimore			5 Other (Special Service Lice		Wesi		Star Ce	es of Famility	1/30/98	11) 101	7/10	in Ma.
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S	Attending or death. Sector: Afte by the fune liftcation	2 ☐ Accident 3 ☐ Suicide	Investigat	be One Diese of	Injury - At home	of farm stre	et, factory, office	74	28f. Location (Street and Numi	ber of Rur	al Route Number,
Division		Homicide	e determine	building,	etc. (Specify)	CFR	FPT		City or To	wn, State)	1250	2
Ξ	Hospital 24 hours e Funeral E letely filled		1□ Certifying I	Physician: To the be	st of my knowle	edge, death	occurred at the ti	ne, date and place	and due to the	cause(s) and m	anner as	stated.
	To the Hospital or within 24 hours efte within 24 hours efte completely filled in Medical Cert	(Check only one)		aminer: On the basis and manner	s of examination							
	Within 2 To the comple		nd title of certifier	1 .	^		29c. Licens	se number		29d. Date signe	ed (Month,	Day, Year)
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	1)	30. Nume and ad	dress of person wh	o completed cause of	of death (Item 2)	3a) (Type, I	Print)					
	1/1	1 1 140	FINI I A	11.5 11. 1	1 /		III Pen	n Street.	Baltim	ore. Ma	rylar	nd 21201

State Registrar Day, Year) June 32 Begistrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Mary 11:58 Am /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Howard County General Hospital Columbia Howard County 7. Age (In yrs. lest birthday) ff Under 1 Year If Under 24 Hrs. 5. Societ Security Number Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) **Funeral** 1 M 2 F Yrs. Director 417-05-4350 78 February 13,1919 Alabama Usuel Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Department of Heelih end Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Madical Examine must be routled at any Injury or other traumatic event, The Madical Examine must be routled at Maryland Howard County Ellicott City 1 ☐ Yes 12 TV No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5192 Bonnie Acres Drive 21043 IISA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien Bleck, White, etc. 1 Never Merried 200 Married 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0020 Specify:White 1 Yes ≥CXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grede com, 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) teacher education 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be William James Curtis Alma Brewer 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 5192 Bonnie Acres Drive, Ellicott City, MD 21043 Ms. Sadie Jacquelyn Waller/daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Buriai 2 ☐ Cremation XX Removal from State Jefferson Memorial Gdns. 3FEB98 4 ☐ Donation 5 ☐ Other (Specify) Trussville, AL 22. Name end Address of Fecility Slack Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory errest. Approximete Intervel Between Onset end Deeth **Physician** /Medical mmediate Ceuse (Finel disease or condition resulting in deeth) . Coronary Examiner ongestive sician and burial-transit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in death) Last Due to (or es e consequence of) physician s the burial Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of) Pert II. Other elanificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 8 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 舞 2 90ed 2 No certificate 1 Yes Be 25. Wes case referred to medice 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Propatient 2 ER/Outpetient 3 DOA 差 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: Ather Neturet 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier [SectifyIng Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. Medical 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steled. 29d. Dete signed (Month, Dey, Yeer) 29b. Signeture end title of certifier 29c. License number

State Registrar

31. Dete filed (Month, Day, Yeer) FEB 0 2 1998

Sikeman

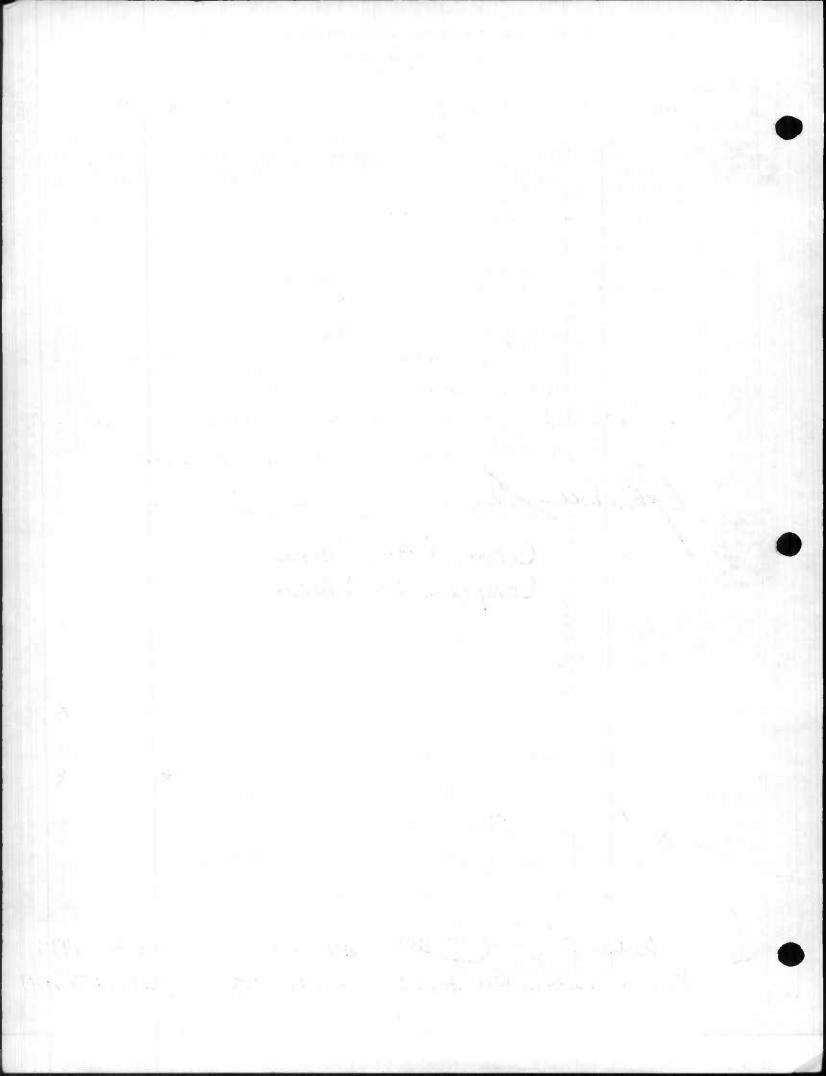
30. Name end eddres

County General Hosp Columbia MD 21044 Howard 32. Registrer's Signeture

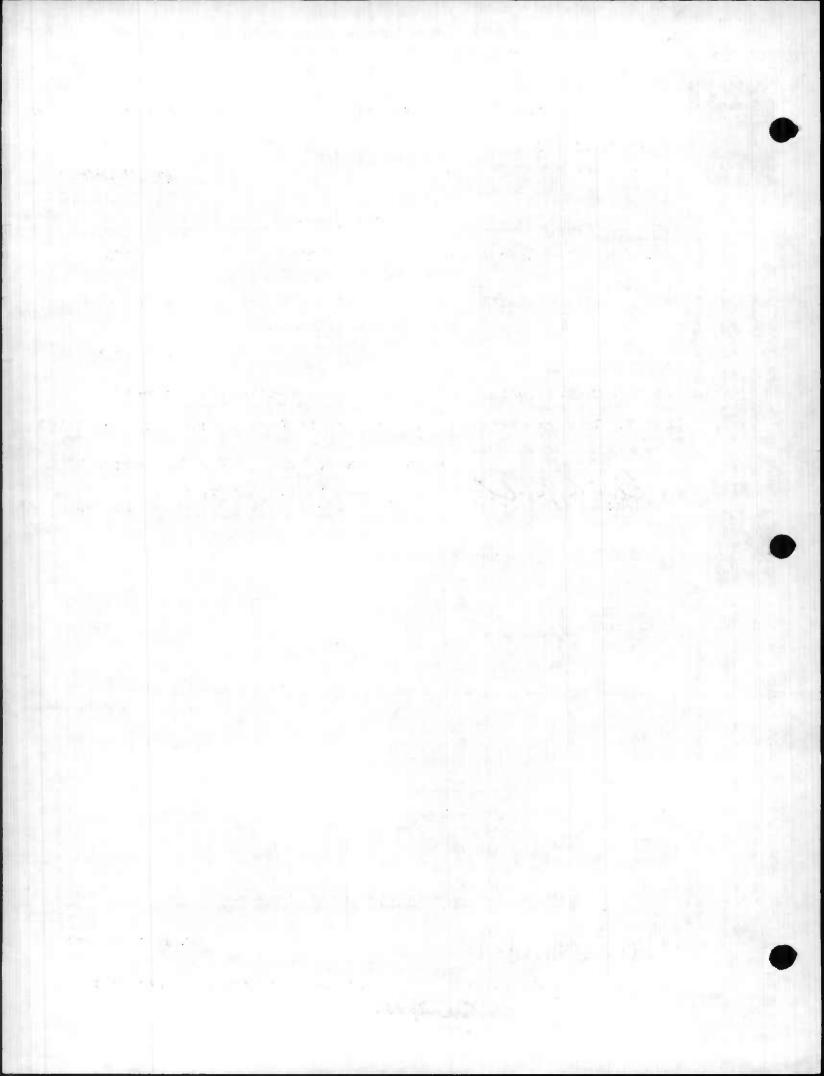
ress of person who completed ceuse of deeth (Item 23e) (Type, Print)

MD

The Davidson

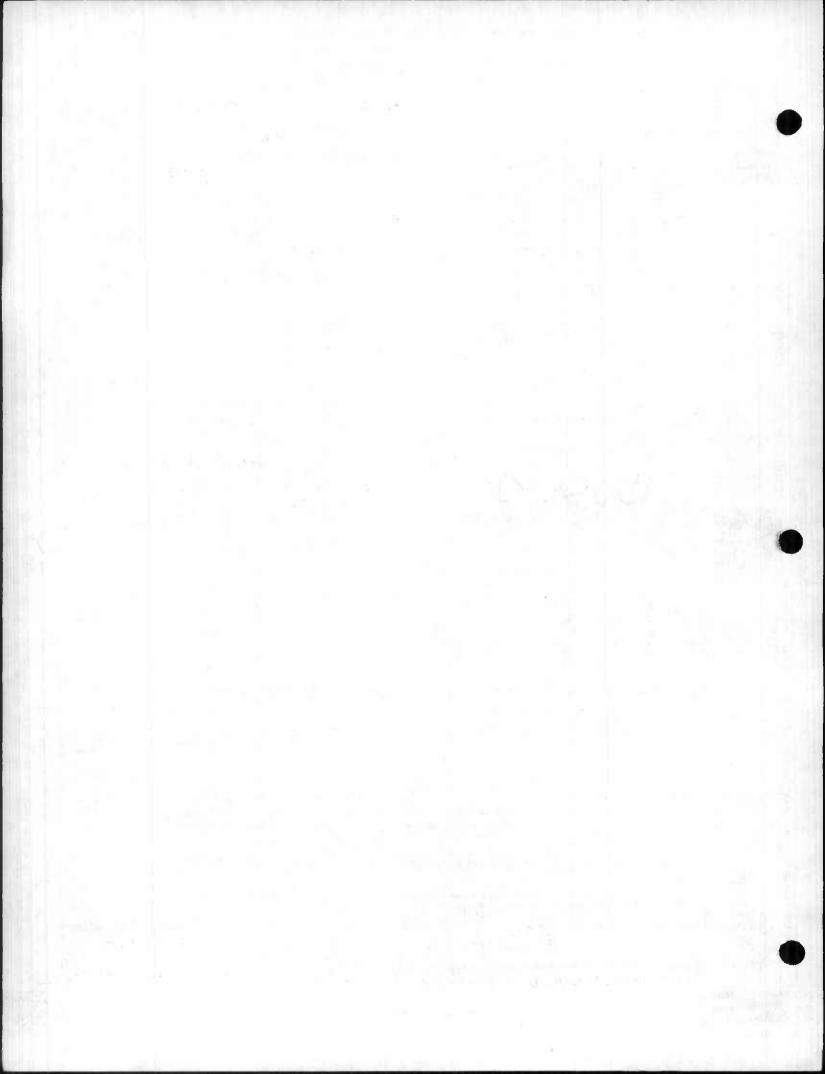


PATRICIA ANN	State of Maryland / l :23a part I,27,28a-f per MEO G-756 2/9/98 dh	Department of Health and MacCertificate of Death	20	02616
Physician	1. Decedent's Name (First, Middle, Last)		Reg. No. 2. Dete of Death Month Dey	Yeer 3. Time of Death
/Medical	Patricia Ann Rich 4a Facility Neme (If not Institution, give street end number)	ardson 4b. City, Town, or Lo	JANUARY 30, 190 cation of Deeth 4c. County	
Funeral Director	ST AGNES HOSPITAL, 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest bit 219-70-5836 1□ M 25√x 42	RALTIMOR Thdey) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min.	8. Date of Birth (Month, Dey, Year) JAN 01, 1956	N/A 9. Birthplece (State or Foreign Country) Maryland
and w	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location	,	10d. Inside City Limits
death with the Maryland rms 23s or 28s-f show prival be notified at	MD Baltimore	Baltimore		1 ☐ Yes 21 No
ith the	10e. Street end Number	10f. Zip Code	10g. Citizen of \	Vhat Country?
auth w	4307 Wilkens Avenue Apt. E		neitr Ven er Ne	USA e - American Indian,
5 22 5	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispenic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 2⊠ No Specify:	Rican, etc.) Specify	ck, White, etc.
Maryland 21215-0020 dd 2 should be flied within 72 hours after the and Mental Hygiene. 77 is marked other than "natural", or its traumatic event, the Marical Example To Be Completed by Fur	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupetion (Give kind of work done during most of work life. DO NOT use retired)		usiness/Industry
1 212 lied withi tygiena. her than mt, the M	1 2 W	aitress	Food (First, Middle, Meiden Sumen	Service
Maryland 2: 2 should be filed v 1 and Mental Hygies Is marked other t reumatic event, the				
Maryla d 2 should th and Men 7 is marke traumatic	John Augustus Cook, SI.	D. Mailing Address (Street and Number or Run	cia Ann Arno el Route Number, City or Town,	
Battimore, Me John R. Pages 1 and 2: Department of Health at Important: If Item 27 is my injury or other treu	20a. Method of Disposition 20b. Plece of	O University Ave. Disposition (Neme of ry, cremetory or other plece)		MD 21228 City or Town, Stete
Itim		Crematory, Inc.	02/02/98 Baltim	ore, MD
Ba perm perm perm perm perm perm perm perm	Elwa & Juyl	MacNabb Funeral	Home, P.A.	
Physician	23a. Pen1. Enter the diseese, or complications thet ceused the death. Do shock, or heart failure. List only one ceuse on each line.	301 Frederick Rd not enter the mode of dying, such as cerdiac	. Catonsvil or respiretory arrest,	1e, MD 21228 Approximate Intervel Between Onset end Deeth
/Medical Examiner	resulting in death) Due to (or es e	ALCOHOL INTOXICATION consequence of):		
60, be axecuted loien and bural-transit	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury Couse)	consequence of):		
687 ficata physis the	that inflieted events Due to (or es e	consequence of):		
Bo Baath daath of for u	Pad II Other algoriticant conditions contributing to death but not requisite.	n the underlying serves given in Bort I	22h Did tohacco una co	ntribute to the cause of death?
P.O. that the deater bed by the deater bed datached	Part II. Other eignificant conditions contributing to death but not resulting in	in the underlying cease given in Part I.		3 □ Probably 4 □ Unknow
Division of Vital Records, P.O. Box 68 for Attanding Physician: The law requires that the death cartifica after death. Director: After this cartificate has been signed by the attanding phy the funeral director, page 2 should be detached for use as the ertification: To Be Completed by Physician/Medi			24e. Wes en eutopsy performed?	24b. Were eutopsy findings evailable prior to completion of cause
Tha law ata has l paga 2 c			Yes 2□No	of deeth?
Vital I	25. Was cese referred to medical	26 Place of Deet	h (Check only one)	1 94es 2 No
of Vital yelden: yelden: director, To Be C	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Other:	me 5 Residence 6 Oth	er (Specify)
Vision of Vita Attending Physician: In death. ector: After this cartificially the funeral director. Milication: To Be (1 □ Natural 5 □ Pending (Month, Dey Year)	Time of A 28c. Injury et Work?	28d. Describe how injury occur	ber
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	4 ☐ Homicide 5 ☐ Homicide 5		City or Town, State) 4307 Baltimore, Marylar	Wilkens Avenue,
Division (To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funer. Medical Certification:	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge conditions on the basis of examination er and menner stated.	e, deeth occurred et the time, date end plece,	end due to the ceuse(s) end me	enner es steted.
DIA, within	29b. Signature and title of certifier	29c. License number CCME		30, 1998
3	71-10-10-10-10-10-10-10-10-10-10-10-10-10	ll Penn Street, Balti	more, Maryland	21201
State Registrar	31. Date filed (Month, Dey, Year) 32. Begistra's Signature FFB 0 2 1998	indell		



State of Maryland / Department of Health and Mental Hygiene 8 02617

Physic						t Death		Reg. No.	
	ian	1. Decedent's Name (First, Middle, La			D ' 1		2. Dete of D	Day	3. Time of Deeth
/Medi		Jacklyn	N	•	Rites		Januar		998 3:30 PM
Examir	ner	4e. Fecility Name (If not institution, given 316 Ternwing Dr.				Ar	n, or Location of Dee NOId		Anne Arundel
Funeral Director		216-36-1362	Sex 7. Ag	e (In yrs. last birthda 58 Yrs.	Months Dey		Min. 8. Dete of Bi (Month, D Dec. 4	ey, Year)	9. Birthplece (State or Fore Country) Naryland
dand www.		Usuel Residence of Decedent 10e. State 10b. County		10c. City, Town or	Location				10d. Inside City Limi
with the Maryland a or 28a-f show the notified at	ector		Arundel	Arı	nold				1□Yes 2⊠h
5 2	Funeral Director	316 Ternwing D	rive		10f. Zip Code	21012	2	10g. Citizen of	What Country? USA
	by	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Dates:	Ever in U,S. 13	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛱 No		n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Rac Ble Specify	ce - American Indien, ck, White, etc. y: White
a within 72 hours after iene. Then "naturel", or ite the "hedical Examine.	Completed	15. Decedent's E (Specify only highest gn Elementary/Secondary (0-12)	ducation ede completed) College (1-4or 5	(Gir	cedent's Usual Occi ve kind of work don b. DO NOT use retir Secreta	e during most (red)	of working	15	usiness/industry 1edical
should be filed with the Mental Hygier the marked other the matic event, t	To Be C	17. Fether's Neme (First, Middle, Last John	Hunt			18. Mother	s Name (First, Middle Mary		erson
and and is m		19e. Informent's Name/Relationship (or Rure/ Route Numbe, Arnold,		
2 5 5 5		20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif		20b. Plece of Dis	position (Name of remetory or other pi	lece)	Feb. 2	20c. Location -	city or Town, State
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lioe	nsee		22. Name end Add Stallir	ress of Fecility	eral Home,	P.A.	
hysician '		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications the caused one cause on each lin	the deeth. Do not e	3111 MC enter the mode of dy	ountain ving, such es ca	Road, Pas ardiac or respiratory of	adena, M prrest,	Approximete Intervet Between Onset end Deeth
/Medicai Examiner		Immediate Cause (Finel disease or condition resulting in deeth)	· Coreg	extine	Heart	Lou	Cene		2-3lay
e is	iner		Sen	Due to (or as a cons	equence of):	U			44n.
cerimicate be executed ding physician and ise as the burial-transit	v/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet Initieted events resulting in deeth) Lest	c	Due to (or as e conse					
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	/Me	Ceuse (Disease or injury thet Initieted events resulting in deeth) Lest	d	It not resulting In the		iven in Pert I.	23b. Dld	tobacco uee co	ntribute to the cause of deat
	Physician/Me	Pert II. Other significant conditions of	dontributing to death bu	it not resulting In the	underlying cause g	iven in Pert I.			ntribute to the cause of deat
aw requires trature death is been signed by the atter 2 should be detached for t	by Physician/Me	Pert II. Other significant conditions of	dontributing to death bu		underlying cause g	iven in Pert I.	1 1 2 24e. Wes		
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ingercent, the law requires that the beath this certificate has been signed by the atternal director, page 2 should be detached for the	To Be Completed by Physician/Me	Pert II. Other significant conditions of Portion Co. 25. Wes case referred to medical examiner? 1 Yes 2 No. 27. Menner of Deeth 1 Neturel 5 Pending	d	Melas for	underlying cause g	26. Plece o	24e. Wes perfect only ling Home 5 President 28d. Describe	en eutopsymmed? Yes 2 DNo	3 Probably 4 Unkno 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 1 Yes 212 No
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insuren. The law requires that the beath his certificate has been signed by the attention director, page 2 should be detached for a	ledical Certification: To Be Completed by Physician/Me	25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 1 Actident 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Exam	d	nt 2 ER/Outpatie y Year) 28b. Time Injury ry - At home, farm, s. (Specify) f my knowledge, dee	ent 3 DOA of 28c. Inju. M 15 street, factory, office the to investigation, in my 29c. Licen	26. Plece of ther: 4 Nursury et ork? Yes 2 No	24e. Wes performed at the time,	en eutopsy primed? Yes 2 D No primed? Yes 2 D No primed? Yes 2 D No primed? Yes 2 D No primed? Yes 2 D No primed?	3 Probably 4 Unkno 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 Yes 2 IZ No er (Specify) red er or Rural Route Number, enner es steted. end due to the ceuse(s) d (Month, Dey, Year)
ingercent, the law requires that the beath this certificate has been signed by the atternal director, page 2 should be detached for the	Medical Certification: To Be Completed by Physician/Me	25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 2 Accident	d	nt 2 ER/Outpatie Year) 28b. Time Injury ry - At home, farm, s. (Specify) f my knowledge, dee exeminetion end/or led.	ent 3 DOA of 28c. Inju. Street, factory, office the courred et the tinvestigetion, in my	26. Piece of ther: 4 Nursury et oht? Yes 2 No opinion, deeth opinion, deeth use number	24e. Wesperful 1 Deeth (Check only) Ing Home 5 PAesi 28d. Describe 28f. Location (City or To	en eutopsy primed? Yes 2 DNo primed? Yes 2 DNo primed? Yes 2 DNo primed? Street end Numb primed placa, which is a pri	3 Probably 4 Unkno 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 Yes 2 IZ No er (Specify) red er or Rural Route Number, enner es steted. end due to the ceuse(s) d (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 29, Pauline Stevenson January 1998 2:05 P.M. /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1805 Thomas Ave Baltimore
If Under 24 Hrs. 8. D. 5. Social Sacurity Number If Under 1 Yaar 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 20xF Months Days Hours Min 220-20-3184 50 Yrs. Director 11-18-192 Md Usual Residence of Decedent 10b. County nd other than "neturel", or items 23e or 28a-f show event, the Medical Example: must be notified at 10c. City. Town or Location 10d. Inside City Limits Md Director NIA 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1805 Thomas Avenue 21215 death Funera 12. Was Decedenl Ever in U,S. Armed Forces? 1 ☐ Yas 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If them 27 is marked other than "neturel; or the any injury or other traumatic event. It a Medical Ferrice. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: **Black** ð 2 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry N/A (1-4or 5+) Elementary/Secondary (0-12) I2th grade Sales Clerk Unknown 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Oscar Wilson Ethel Shelton 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Linda Sloan Daughter 2917 Gwynns Falls Parkway Baltimore, Md 2: 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Ramovel from State 4 Donation 5 Other (Specify) 2-3-98 Baltimore, Md Loudon Park Cemetery 21. Signatura of Funeral Sarvice Licensee March F/H West Wabash Avenue Baltimore, Md 21215 Enfort the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Batween Onsat end Death **Physician** Immediate Cause (Finel diseese or condition resulting In death) /Medical METASTATIC CARCINOMA OF THE BREAST Examiner Physician/Medical Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760. Dua to (or es e consequence of): P.O. | ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobaccq use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed b Division of Vital Records. ð 24b. Were autopsy findings aveileble prior to completion of cause of death? page 2 should Completed 24a. Was an eutopsy performed? certificate or Attending Physician: 25. Was cese referred to medical exeminer? director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home Certification: To 5 Residence 6 Other (Specify) a ster dea... 27. Manner of Death Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours and To the Funeral Completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end manner as stated.

2 Madical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medicai 29a. Certifier (Check only one) To the 29b. Signature and litle of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year)

LINIV. OF MARYLAND, 22 SOUTH GREENE ST

Registrar

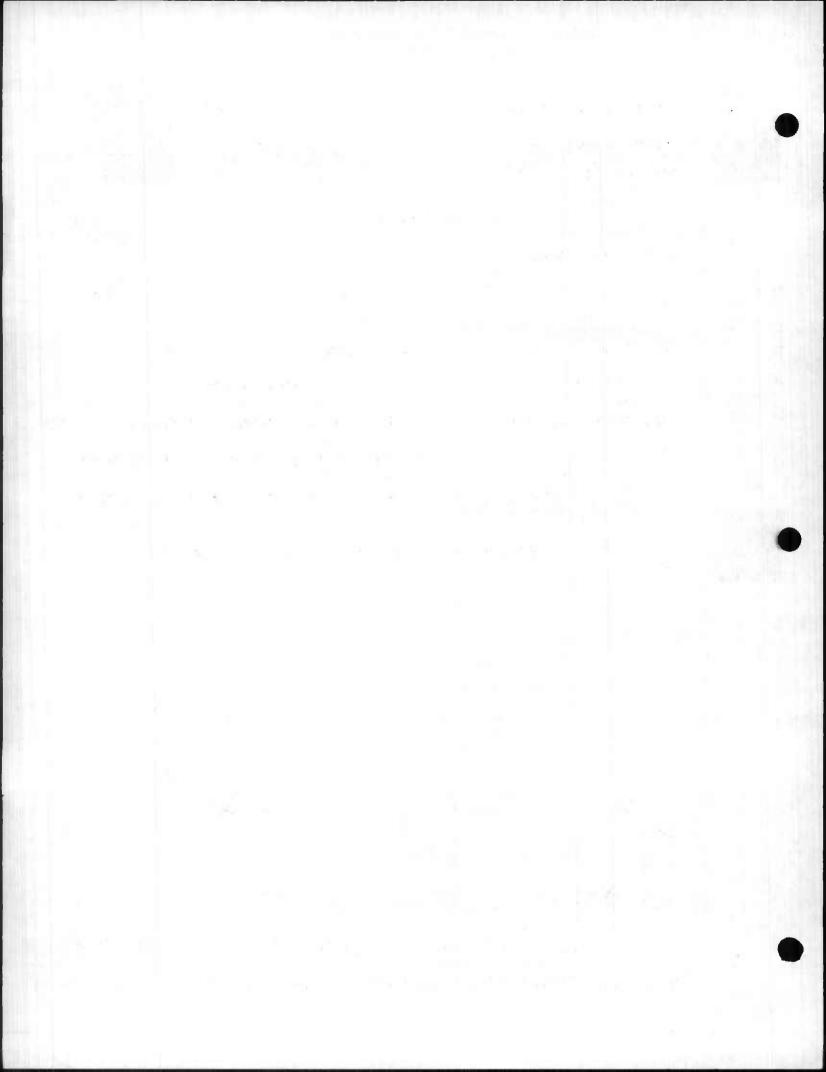
State

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

0 2 1998

32. Pogistrar's Signature

31. Dete filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name /First Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Day Stewart, Ir 3:201/ SANUARY /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Name (If not institution, give street end number 4c. County of Deeth **Examiner** Baltimore HOS If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) OCTOBER 27, 5. Sociel Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign Country) **Funeral** Months Deys 100 M 2□ F 249-12-3876 Yrs. Director Ctober 27, 1913 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Hd Baltimore 1 Yes 2 □ No NA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3707 Anenye 21215 238 10 Wanda by Funerai 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Yes 2 DNo f Yes, Give Yeer or Dates: ò Maryland 21215-0020 1□ Yes 20 No Specify: Black 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiena. Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Construction Construction grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Stewart 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) mit. Pages 1 end 2 st pertment of Haalth an portant: If Itam 27 is r y injury or other traus Sister 3707 Balto, Md 21215 Hvenus 1 owanda houise Baltimore, 20e. Method of Disposition

1 Buriel 2 Cremetion 3 Removal from State 20b. Plece of Disposition (Name of Dete 20c, Location - City or Town, Stete permit. Page Depertment of Important: If I any Injury or once. Randallstown, nd 2-3-4 ☐ Donetion 5 ☐ Other (Specify) Hart 21. Signeture of Funeral Service Licansee 2/2/5 Wabash Balto, Md 300 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Physician /Medical Immediete Ceuse (Finel disease or condition resulting in death) UNKNOWN Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760. physician the Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel exeminer? Be 26. Plece of Deeth (Check only one) STE //A MARIS 1□ Yes 2□ No Other: 4 Nursing Home Certification: To 5 Residence 6 Other (Specify) Hospic E 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 1 Accident 5 Pending Investigation 1 Yes 2 No after deeth Director: A 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted. 29a. Certifler Medicai pletaly (Check only one) 29b. Signeture end title of cartifier 29c, License number 29d. Date signed (Month, Dey, Year) J. Marso us 040480 JANUARY

State Registrar 31. Dete filed (Month, Day, Year) FEB 0 2 1998

FERENANDO

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

2. Registrer's Signeture

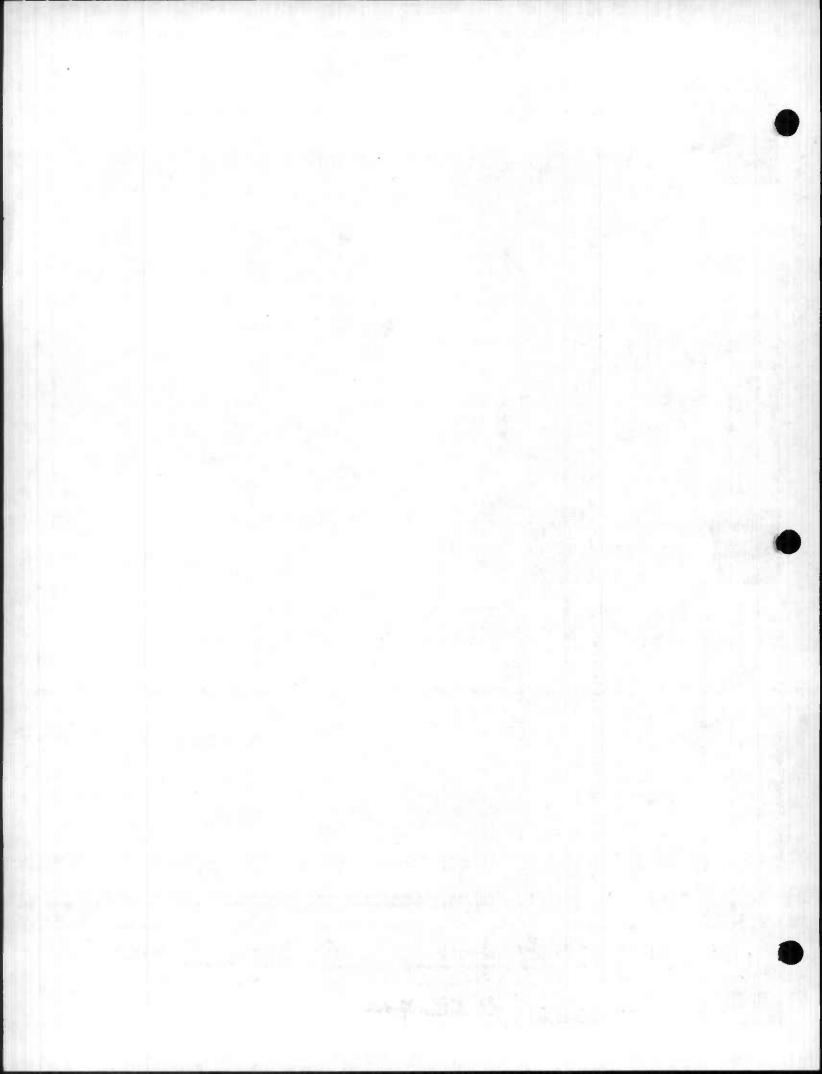
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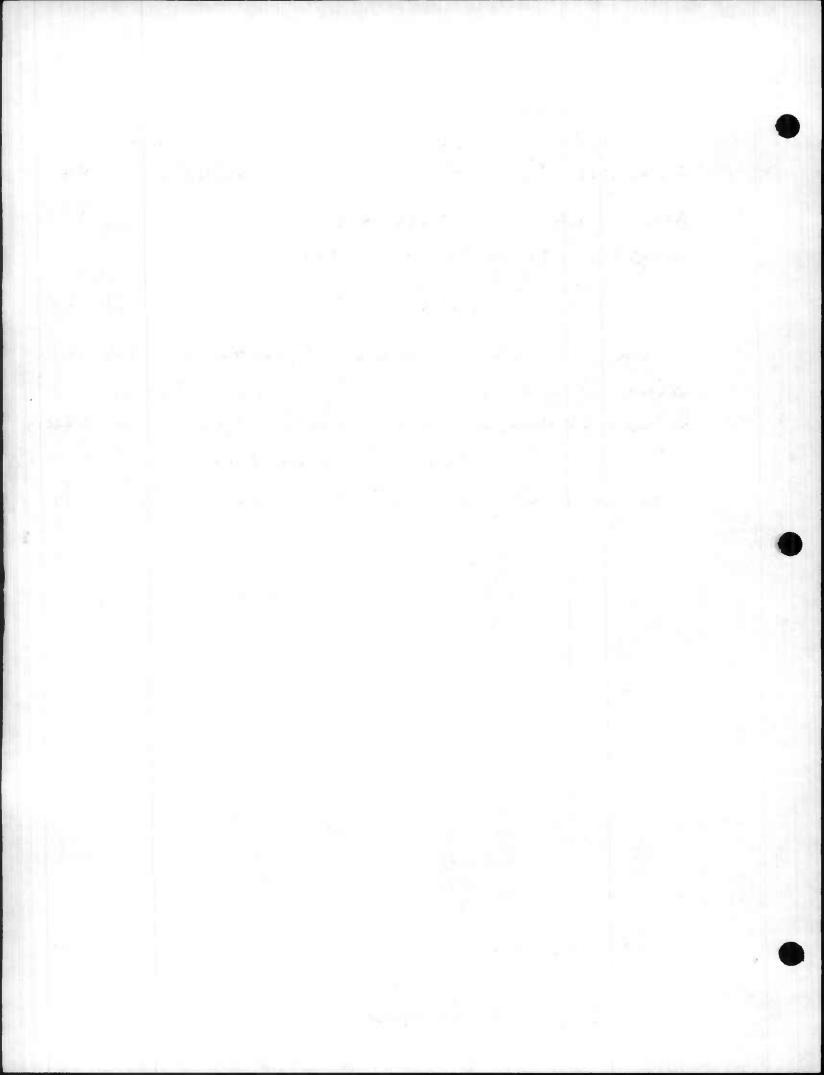
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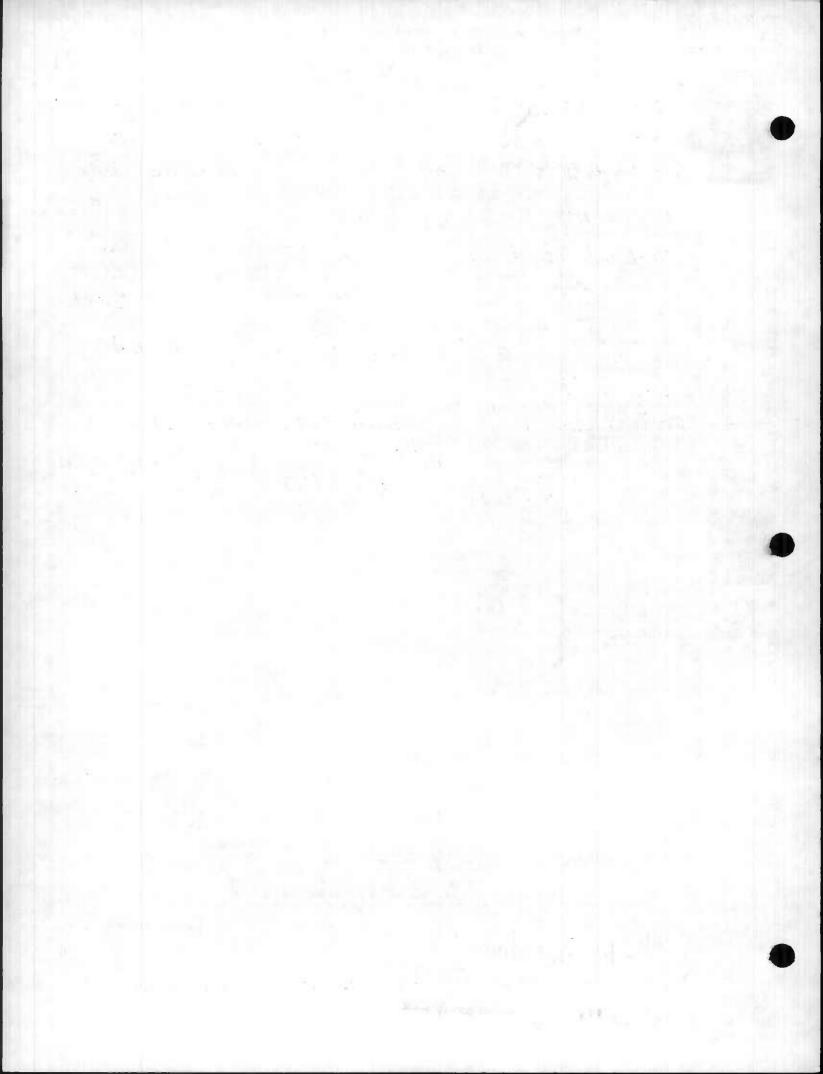


State of Maryland / Department of Health and Mental Hygiene 8 0 2 6 2 0

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	Physici		Colorry Ski	nner				1 6		28 19	Year 198	1210m
	/Medic Examir		4a. Facility Nama (If not institution, giva			-	4b. City, Tov	wn, or Location		4c. County of	1 -	12 pinc
	Examili	iei	9 11	0 - "	-		- 11	timore		NA		
	F		5. Social Sacurity Number 6. Se	of Baltimor		dar 1 Year	If Under 2	24 Hrs o Do	to of Dieth		-	on /Ctata or Famina
	Funeral Director			2M 2□ F 0 4	Yrs. Monti		Hours	Min (M	onth, Day, Yae	(1)	Countr	ca (State or Foreign
	Director		Usual Residence of Decedent	11				36	p. 6,10	123		"VA
and	Mo TH		10a. Stata 10b. County	10c. Ci	ty, Town or Location						100	d. Inside City Limits
Maryland	a p	ō	AN AM	B	1110	00 -						1 No Yes 2 No
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with the	0 3	Ö			3.0	Zip Code				Citizen of W	hat Countr	y7
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ar de	itams rest its	Funerai	11. Marital Status	12. Was Decedent Ever in U Armad Forces?	I,S. 13. Was De	cedent of H pacify Cuba	lispanic Orig an, Mexican	gin? (Specify Yo , Puerto Rican,	etc.)		 Americal White, et 	
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Maryland	is m		Ma. Informant's Name/Relationship (T)	pe, Print)	19b. Mailing Addr	ess (Street	and Numbe	er or Rural Rout	e Number, Clty	y or Town, S	Stata, Zip C	(ode)
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or e			20a. Method of Disposition		Placa of Disposition (/	Vame of	ce)	Date	20c.	Location - C	ity or Tow	n, State
T ag	X THE		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from Stata	7	10 C+ 4	· (lot	17.4	98 O	26.60	Mz	Ile Hel
Baltin Permit. P	Departmer Important: any Injury once.		21. Singura of Funeral Sarvica Licens		22. Name	and Addres	ss of Facility	v %	(11	WING	7216	7
M E	Depa Impo any Ir		NO.	AL.	Wm	C.M	arch	tun-e	4	one l	real	-fre
		_	Julyne 13.	Jane			bast			B a		1215
			23a. Part Enter the disease, or complessions, or hear failure. List only of	na cause on each line.	n. Do not anter the m	node of dyln	ig, such as o	cardiac or respi	ratory arrest,		10	Approximate nterval Batwaen
	ysician											Onset and Daath
	/ledical aminer		Immediate Causa (Final disease or condition rasulting in death)	pneum	onia,	aspic	atio	2				2 hour
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78	Sit.	ine		, metastati	c adenoco	arcin	oma	of ux	KNOU	Ya ac	Mains	2 months
acut	physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying	Due to (d	or as a consequenca o	of):					J	
90,	cian		cause. Enter Underlying Cause (Disease or injury								1	
x 68760, ertificate be execu	e ettending physic d for use as the b	Medicai	that initiated events resulting in daath) Last	Due to (c	r as a consequence o	vf):						
X 6	ng b	Me									ŀ	
a 0	endi r use	an										
. 8	the ett	Sici	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlyin	g cause giv	an in Part I.	2:	3b. Did tobeco	co use conf	ribute to t	he cause of deeth?
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ords	n sig	8						24	la. Was an au		24b. Wara	a autopsy findings
00 0	been si should	ete							performed?		com	able prior to pletion of causa
Records,	has 3e 2	Completed									of da	iath?
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of Vital	s certificate director, pag	Be	25. Was case refarred to medical examinar?	le ambie i				of Death (Chec	ck only one)			
De la la la la la la la la la la la la la	(0 T)	2	TO THE ZININO			DOA Oth	4 🗆 1401	rsing Home 5				
C gu	ther	E O	27. Manner of Daath 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl			escribe how in	jury occurre	đ	
Vision	or: A	cati	2 Accident invastigation		М	10	Yas 2□ñ	Vo				
Division	ract	É	3 Suicide 6 Could not be datermined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fact	tory, office		28f. Lo	cation (Street	and Numbe	r or Rural I	Route Number,
io is	a Die	Certification:			,					ĺ		
Hoapital	non Juner	ca	29a. Certifier Certifying Phys	sician: To the best of my kno	wledge, death occurre	ed at the tim	ne, date and	d place, and du	e to tha cause	(s) and man	ner as stat	ed.
H ac	n 24	edical	one)	ner: On the basis of examina and manner stated.	tion and/or investigati	on, in my of	pinion, daati	n occurred at th	na time, date a	ind placa, ar	nd due to ti	na causa(s)
To tha	witnin z4 nours effer death. To the Funeral Diractor: Affer this completely filled in by the funeral to	Z	29b. Signature and titla of certifier			29c. Licanse	a number		29d. D	ate signed	(Month, De	ay, Year)
	1		& Karma	MD	Δ	874	1077	274191	22 h	NURY	128	1998
1	IXI	-	30. Name and address of person who co	implated cause of death (Iter	1 23a) (Ivna Print)			325191			7 - 2) (1 , 0
	10,		Sin A Vann	I am O	nai Hos	1.1.	20	2011	m(-)			
	Sta	e e	31. Date filed (Month, Day, Year)	32. Registrar's Signs	itura	- I cal	or of	MITTIN	UIE .			
	Registr		FFR 0 2 199	32. Registrar's Signa	In Bankage							

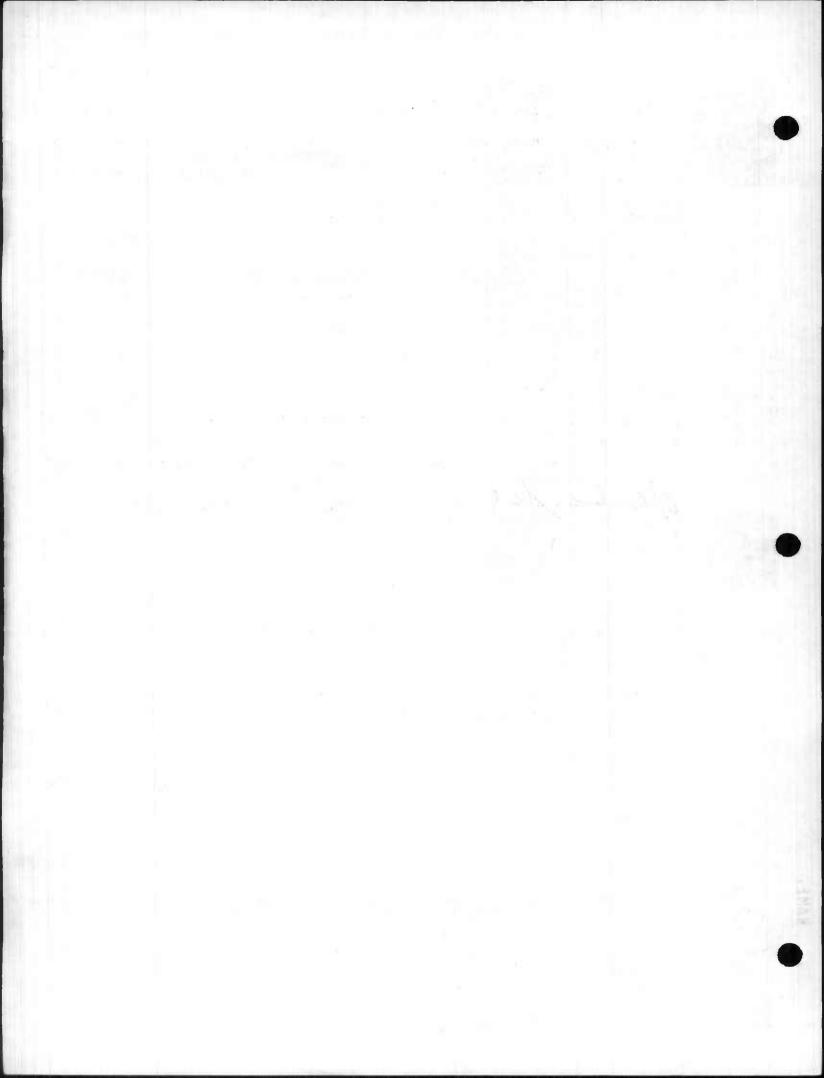


	K HN STEW	AR		State of Marylan					00001	
			: I,27,28a-f per MEO G		Certificate			Reg. No.	02621	
			. Decedent's Name (First, Middle, La			The same	2. Data of Dec		3. Tima of D	Death
и	Physici /Medic		John Sto	mart			JANUAF	Day 24, 19	998 0115A	M
	Examin		4a Facility Name (If not institution, giv	a street end number)		4b. City, Town, or L				
			UNIVERSITY HOSPIT	AL E.R.		BALTIMORI	E CITY	^	1/a	
	Funeral		5. Sociel Security Number 6. S	7. Aga (In yrs.	Months D	rear If Under 24 Hrs. lays Hours Min.	8. Date of Birt (Month, Da	h y, Year)	Birthplaca (Stete or Cauptry)	Foreign
	Director		Usuel Residence of Decedent	3	9 Yrs.		120,	1938	maryla.	na
	Man Man		10a. State 10b. County	10c. Cit	y, Town of Location				10d. Inside City	Limits
	Many Fed	to	md N/a	6	altimore				1 2 Yes	2 No
	ch the Maryland or 28a-f show as notified at	Director	10e. Street and Number	() /	10f. Zip Co	de		10g. Citizen of W	hat Country?	
	after death with the Marylar or litering 23s or 28s-f show miner must be notified at		904 W. Lomb	and St.	2	1223		U.	54	
	r des	Funeral	11. Maritat Stetus	12. Was Decedant Ever in U. Armed Forces?	S. 13. Was Deceden tf Yes, specify	t of Hispanic Origin? (Sp Cuban, Maxican, Puarto	pecify Yas or No Rican, atc.)	14. Race Black	- American Indian, k, White, etc.	
20		by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 🔀	No Specify:		Specify:	Rlack	
21215-0020	hours.		15. Decedent's E	Yaar or Datas:	16a. Decedent's Usuel C	ccupation		16b. Kind of Bu	siness/Industry	
215	in 72 n "na hedio	plet	(Specify only highest gre Elementary/Secondary (0-12)	ede completed)	(Give kind of work of life_DO NOT use i	fone during most of work	king		- 4	
217	d with plans or tha	Completed	La La La La La La La La La La La La La L	College (1-4or 5+)	Bus.	Driver		M. T.	A	
	tal the dother went	Bec	17. Father's Name (First, Middla, Last,	1-		18. Mother's Nem	ne (First, Middla,	Maiden Sumem	9)	
yla	Mant Marria arka arka	10	Edward Steu	wart (c)		Lena	Lu	C		
Maryland	ta 2 sh h and h sen resum		19a. Informent's Name/Relationship (Type, Print) (WIFE)	19b. Mailing Address (S	treet end Number or Ru	Pal Route Number	er, City or Town,	Stete, Zip Code)	
10	1 and Health		20a. Method of Disposition	20b. F	1 4 04 W. LON	of Dara ST. E	Date Date	20c Location	City or Town, Stata	
nor	nt of the same		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crematory or othe	r place)		1 . 1 . 1	1	
Baltimore	arthro ortan		4 ☐ Conation 5 ☐ Other (Specification 21, Signature of Funeral Service Licer		22. Name end A	ddress of Facility	2222	111,100	nd. 21216	
Ba	Dep Dep amy		A real of	Reli	JOSEP	h L. Russ	Bath	more. I	nd. 21216	
	-		23e. Part1. Enter the disease, or com	plications that causad the daat	h. Do not entar the mode o	a Home f dying, such as cardiac			Approximate	
(8)	Physician		meck, or heart failure. List only	one cause on each line.					Onsat and D	een aath
	/Medical		tmmediate Cause (Finel disease or condition	, NARCOTIC IN	TOXICATION				1	
п	Examiner		resulting in death)		er as e consequenca of):					
	bed is	Examiner		b						
•	be axecuted ician and burial-transit	xar	Sequentially list conditions, if eny, leeding to immediate	Due to (o	r es e consequence of):					
200		100	cause. Enter Underlying Cause (Disease or Injury that Initieted events	C. Due to (o	r as a consequenca of):					
68	certificata nding phys usa as the	Medi	resulting in deeth) Lest	500 10 10	as a consequence on.					
Box	eath certifii attending I for use as	Physician/Medic		d						
	0 0 0	sici	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying caus	se given in Part I.	23b. Did	tobacco use con	tribute to the cause of	death?
P.0	the Second						10	Yes 2 No	3 Probably 4 U	Inknown
Records,	sign d be	d by					24a Wes	en autopsy	24b. Were autopsy tir	ndings
200	_ 0 0	lete						rmed?	available prior to completion of ca of death?)
Re	The law ata has b page 2 s	Completed					<u></u>	res 2□No	10 as 201	Ma
Vital		Be Co	25. Was case referred to medical			26. Place of Dee			101as 201	40
>		ToB	axaminer? 1 M Yes 2 □ No	Hospitel: 1 ☐ Inpatient 2 🖾	ER/Outpatient 3 DOA	Other		denca 6 □Othe	er (Specify)	
n of	F F la		27. Manner of Deeth 1 □ Natural 5 □ Pending	28e. Date of injury (Month, Dey Year)	28b. Time of A 28c.	Injury at Work?	28d. Describe I	now injury occurr	ed	
Siol	Attending ir death. ector: Afte by the fune	catle	2 ☐ Accident investigation	found:1/24/98	found:12:40	1 ☐ Yes 2/03/No	unknown			
Division	fraction by in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At he building, etc. (Specif	ome, farm, street, factory, o	ffice	28f. Location (: City or To	Street end Numbern, Stete) 833	er or Rumel Route Numb N. Fremont Av	enue,
	pital o	Ce	29a. Certifier 1□ Certifying Ph	found:dwelling	and the second of the	to time data and store		, Marylan		
	24 hos Fun etely	edical		ysician: To the best of my kno niner: On the besis of exemina end manner stated.						
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Sign ture and title of cartifier	4.	29c. L	icense number		29d. Date signed	(Month, Day, Year)	
			Mounter	elfall	2	.C.M.E.		JANIIARV	24, 1998	
	2		30. Name and address of person who	completed cause of death (Iten				OLD TOPINI	-11 1000	
			MDRYSONS D	. KORTU dus	111 Penn S	treet, Balt	imore, l	Maryland	21201	
	Sta		31. Dete filed (Month, Day, Year)	Julia Davidson A	ndess.					
	Registr	aı	FEB 0 2 000	0						



State of Maryland / Department of Health and Mental Hygiene 0 00000

					Cei	rtificate	of De	ath		Reg. No.	0 0	2022
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/Medical			harles	1 2	1/10	~	4. 0		JaNe	1	1 1998	
Examiner	ľ	4e. Fecility Neme (If not institution, giv ST. A9 NCS	Hospita	1					ocation of Dee	11	unty of Deeth	
California		5. Sociel Security Number 6. S	-	e (In yrs. lest	hirthday)	If Under 1 1	Year Ht	altimo Inder 24 Hrs.	B Date of Bi	m Ba	Lt1mor	ce City
Funeral Director			M 2□F	76	Yrs.	Months D		ours Min.	8. Date of Bi (Month, D February	24,192	1 Rho	plece (State or Foreignity) ode Island
nd Mentel Hygiena. marked other than "natural", or items 23a or 28a-f show unatic event, the Medical Exercine rural be inclified at To Be Completed by Funeral Director		10e. State 10b. County		10c. City, T								10d. Inside City Limits
28a-f shown		Maryland Baltimo	re County	E	llic	ott Cit	cy.					1 ☐ Yes 2 No
okret must be notified Funeral Director		10e. Street end Number 2601 Westchester	Avenue			10f. Zip Co	ode	21043			of Whet Cou USA	intry?
, A		11. Marital Status 1 □ Never Married 2 □ Married 3/⊠ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Yeer or Detes:	No		Wes Deceden f Yes, specify 1 ☐ Yes 20			ecify Yes or No Rican, etc.)		Race - Amerl Bleck, White, ecify:Whit	, etc.
digal		15. Decadent's Ed (Specify only highest gre	ucation de completed)	1	6e. Deced	lent's Usuel C	occupation	most of work	ina	16b. Kind (of Business/in	ndustry
event, the Medical E		Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. I	DO NOT use r	retired)					
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raumatic		19e. Informent's Name/Relationship (1968). Angela Picket	ype, Print)						ral Route Numb			(p Code) MD 21043
ther	-	20a. Method of Disposition	07 4449.700.			sition (Neme		2 22 0 0 1	Dete		on - City or T	
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e la		4 ☐ Donetlon 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	-	Mead		dge Men			4FEB98	Elkri	dje, M	Maryland
any ir		1. 1	1 ,			515	Cle F	ineral	Home,	P.A.		
	-	23a /Part1. Enter the disease, or ofin shock, or heert feilure. List only	ligations that saused	MOO5	35	E11	Licot	t City	, Maryl	and 21	043	Approvimate
		shock, or heert feilure. List only	one cause on each lin	ne.	JO HOL ON	er the mode o	i dyirig, su	CIT 45 CATGIEC	or respiretory t	mest,	1	Approximete Intervel Between Onset end Deeth
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ě			Hep	10	2 G i	UPP					1	5 days 4 months
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edical Examiner		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	Rili	apy	to	-art	+w	mor			1	4 months
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atached for usa a	F	Pert II. Other significent conditions co	entributing to death but	ut not resultin	g in the u	nderlying caus	e given in	Pert I.	23b. Did	tobacco uae	contributa t	to the cause of death
be datached for usa		Chronic	Obstruct:	ve	Puln	man	2 9	iSeam	- 10	Yes 2□N	lo 3□Pro	obably 4 Unknow
should	-								24e. Wes	en autopsy ormed?	9/	Vere autopsy findings veileble prior to ompletion of cause f deeth?
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ation		1 Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Mortin, De)	rear)	Injury	М	1 ☐ Yes	2 □ No				
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	_		. Kjim,		ν.	L	0005	241	7	Jahu	ary, 3	31,1998
	3	30. Neme end address of person who		_	e) (Type,	Print)	Λ	0 13:0	0 11	**	J	
		LISH M. Kim, r		900 5), (aton	HV	~ NW	. oalt	more	, MD	.21229
State Registrar	3	31. Date filed (Month, Dey, Yeer)	32. Registra	ar's Signature	, 7							
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uneral irector		214-56-6059		™ 2□ F	4		Months	Deys	Hours	Min.	8. Date of B	ay, Year) 1, 195	Co	untry)	
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how m		10a. State 10b. Con	unty		10c. Cit	y, Town or Lo	cation							10d. Inside City	Limits
28a-f show	cto	MD	N	/A			Ва	lti	more					1 ¥Yes	2□Ņo
al', or items 23a or 28a-f sho Examiner must be notified at	Director	10e. Street and Number					10f. Zip					10g. Citizer	n of What Co	ountry?	
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Iner In	Funeral	11. Marital Stetus		12. Was Decede Armed Force	nt Ever in U	,S. 13. V	Was Deced	lent of H	ispenic Orig	gin? (Spe Puerto	ecify Yes or N Rican, etc.)	0- 14.	Race - Ame Bleck, Whit	rican Indien,	
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Ex	d by	3 ☐ Widowed 4 ★ Divo		Year or Date	s:									hite	
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out,	Ö	17. Father's Neme (First, Mid	idle. Last)			500		-			(First, Middle			itty) .
C .V	o Be	James Henr									rine		Farr		
Ther	P P	19a. Informant's Name/Relat	-			19b. Mellin	na Address	(Street			I IIIC				
other traumatic event, the Medical		A													
other		Teresa L. S	tev	ens/vau	20b. F	Place of Dispos	sition (Nan	ne of		E	Balti Dete	more,	tion - City or	Town, State	
0 0		1 Burial 2 Cremat			(O	emetery, crem									
nju		4 ☐ Donetion 5 ☐ Other 21. Signature of Fynerel Sen			met	cro Cre			Inc.	-	1/02/98	ват	timor	e, MD	
Important: if item 27 is marked other than any Injury or other traumatic event, the Moones.		Edward	01.	gregire	Q. J.	C	1401110 011	A Addition	- C	٠.	-		-		
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Michael E. Pelczar, M.D., St. Agnes Hospital, 900 Caton Avenue, Baltimore, MD 21228

32. Registrar's Signature

Registrar

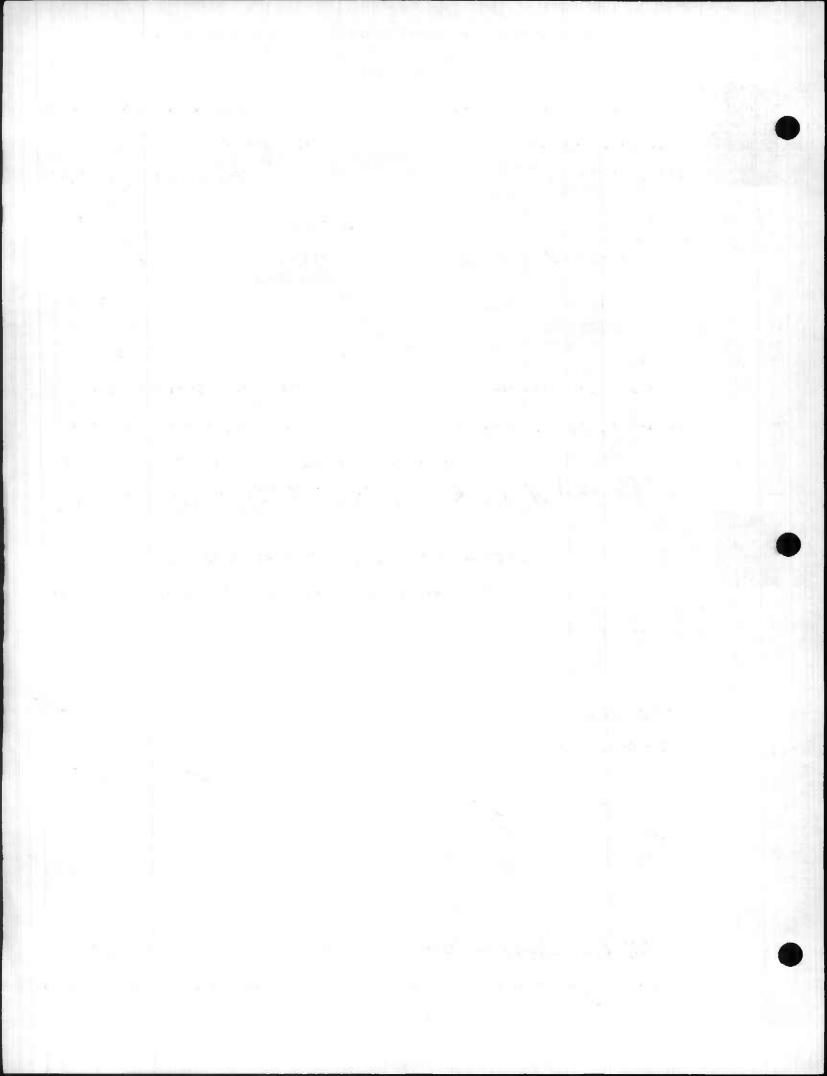
DHMH 16 Rav 6/95

State

31. Date filed (Month, Day, Year)

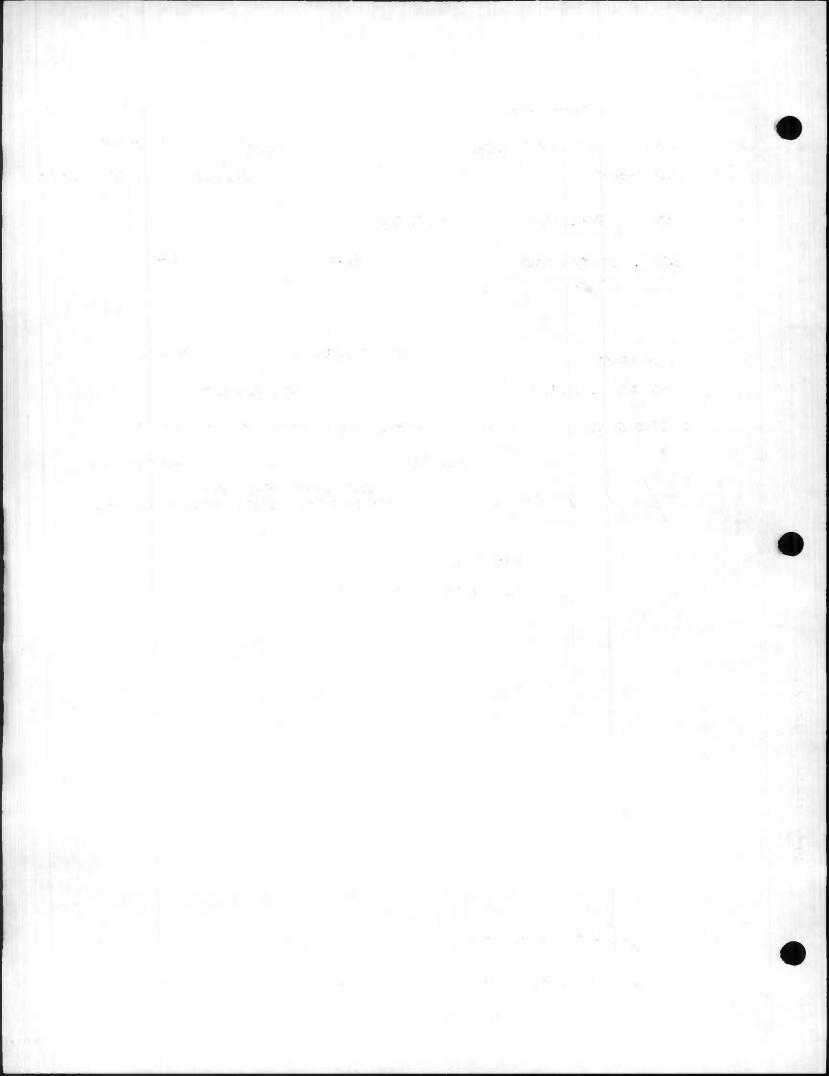
ROLAND STEVENS

NAME: JAMES

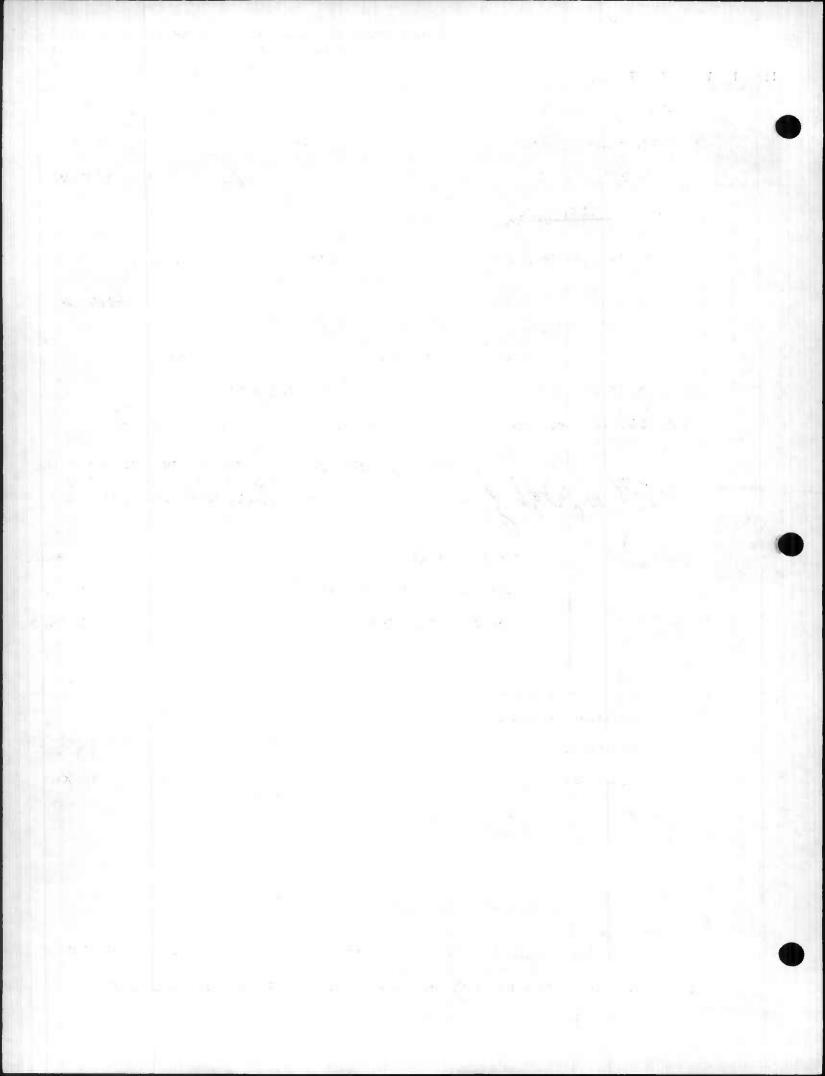


State of Maryland / Department of Health and Mental Hygiene 8 0 2 6 2 4

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		1. Decedent's Neme (F	First, Middle, Las	1)					2. Date o Month		Dey	Yeer	3. Time	of Death
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Examiner	- 12	4e. Facility Neme (If no	ot institution, give	street end number)				4b. City, Town, o	or Location of D	eeth	4c. County	of Deeth		
		STELLA M	ARTS HOS	PICE N.H.				MIT	JTIM		BAL	TIMORE	2	
uneral	5	5. Sociel Security Num	ber 6. Se	7. Age	e (In yrs. la		Under 1 Year	If Under 24 H	rs. 8. Date o	Birth Dev Ye	er)	9. Birthple Count	ece (Stete	or Forei
rector		232-05-64	52	□M 2□F	87	Yrs.			1/18	/191	1			RGINI
>		Usual Residenca of De 10a. State	ecedent 0b. County		10a City	Town or Locatio				1		40	4.1	05 11 5
or 28a-f show a notified at Director							ori					10	d. Inside	City Limit
Series of the se		MD	BALTIMO	RE	PA	RKVILLE							1 16	is 2 LAIN
be notified Director	1	10e. Street end Numbe	er			10	Of. Zip Code			10g.	Citizen of V	Whet Count	ry?	
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al, or items 23a or 28a-f sho Examiner must be notified at by Funeral Director	1	11. Maritel Status		12. Was Decedent E	Ever in U,S	. 13. Was	Decedent of	Hispenic Origin? Den, Mexican, Pu	(Specify Yes o	r No-		e - America		
A F		1 ☐ Never Married		1 ☐ Yes 2X N If Yes, Give	10		res 21/2 No				Specify			
		3 Widowed 4	Divorced	Yeer or Dates:			- LAZ-INO	ороспу.			Specify	WH]	TE	
nt, the Medical of the Completed		(Specify	only highest great	icetion (e completed)		16a. Decedent's	s Usual Occu	pation	vorkina .	16b	. Kind of Bu	usiness/Indi	ustry	
ne du	-	Elementary/Seconda		College (1-4or 5	+)			during most of w						
Cor		12TH GRAI	DE			CHEIF	CUSTO	DIAN		5	SCH00I	_		
a oth	1	17. Father's Neme (Fin	st, Middle, Lest)					18. Mother's N	ame (First, Mid	ddle, Maid	den Sumerr	ne)		
s marked other than aumatic event, trail To Be Comp	L	UNKNOWN	STROTH	ER				ADA	UNKNO	NN				
s ma		19a. Informent's Neme	e/Relationship (T	ype, Print)		19b. Meiling Ad	ddress (Stree	t end Number or	Rurel Route No	ımber, Cit	ty or Town,	Stete, Zip	Code)	
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orta Inc	1	21. Signeture Funer			- ILITATO			ess of Fecility	2/1/9	אַח כ	MKIN	JIV, VV.	VA	
a a a		MILL	4 1	11				UNERAL F						
	+	2/62/	Mr. M.	Haylan	ab a dayab	852	1 LOCH	RAVEN E	BLVD. '	I'OWSC	IM , MC			
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sician													Onset en	Deetn
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-	1	resulting in death)		0.								1		
in e					Due to (or o	es e consequenc	ce of):			_		1		
C 5						es e consequenc Heart Fa								
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month VAR Robert W. Tews Janus 10:15 A-m 27 1928 4a. Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death ARUNDEL HOSPITHL BURNIE NGRTH A.A. COUNTY GLEN If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) 1 M 2 □ F 216-44-3252 Yrs 92 10/31/1905 Germany Usuel Rasidance of Dacedant 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Pasadena 1 X Yas 2 □ No 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 409 Dobbins Lane 21122 United States Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Reca - American Indian, Biack, Whita, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White by 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Spacify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Letter Carrier U.S. Postal Service 11 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Robert Carl Tews Anna Kopf 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, State, Zip Code) Joan Sebald 409 Dobbins Ln. Pasadena, MD 21122
ce of Disposition (Nama of Data 20c. Location - City or Town, Stata 20b. Piace of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) Loudon Park Cemetery | 1/30 | Baltimore, MD 22. Nama and Addrass of Facility Ambrose Funeral Home of 21. Signatura of Funeral Service Licenses Immediata Causa (Finel disaasa or condition resulting in death) Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Diseese or Injury that initiated evants rasulting in daath) Last Due to (or as a consequence of) Due to (or as a consaquance of) Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings eveilabla prior to complation of cause of death? 24a. Wes an autopsy performed? 1 🗆 Yas 2 No 1 Yas 2 No 25. Was cesa rafarred to madicel axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 ☐ Yas 2 No 27. Mennar of Death Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Naturel 2 Accident 5 Pending Investigation 1 Yas 2 No 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 Sulcida 6 Could not be

Division of Vital Records.

physician and the burial-transit cartificata be axecuted as signed by the attending of the deteched for use as should has cartificata funaral director. Aftar daath. To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A complataly filled in by the fu

Physician

/Medical

Examiner

Director

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

al Hygiena.

permit. Pagas 1 and 2 should be file Department of Health and Mantal Hy Important: If Item 27 is marked othe any linury or other traumatic event 2008.

Physician /Medical

Examiner

Physician/Medical

by

Completed

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Certification:

Medical

4 Homicida

29b. Signature end titla of certifier

31. Data filed (Month, Day, Year)

29a. Cartifian

72 hours after death with the Maryland

10 WS. Robert

State Registrar Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, end due to the cause(s) end menner es steted.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and mannar stated. 29c. License number 29d. Data signed (Month, Day, Year)

405

1/27/98

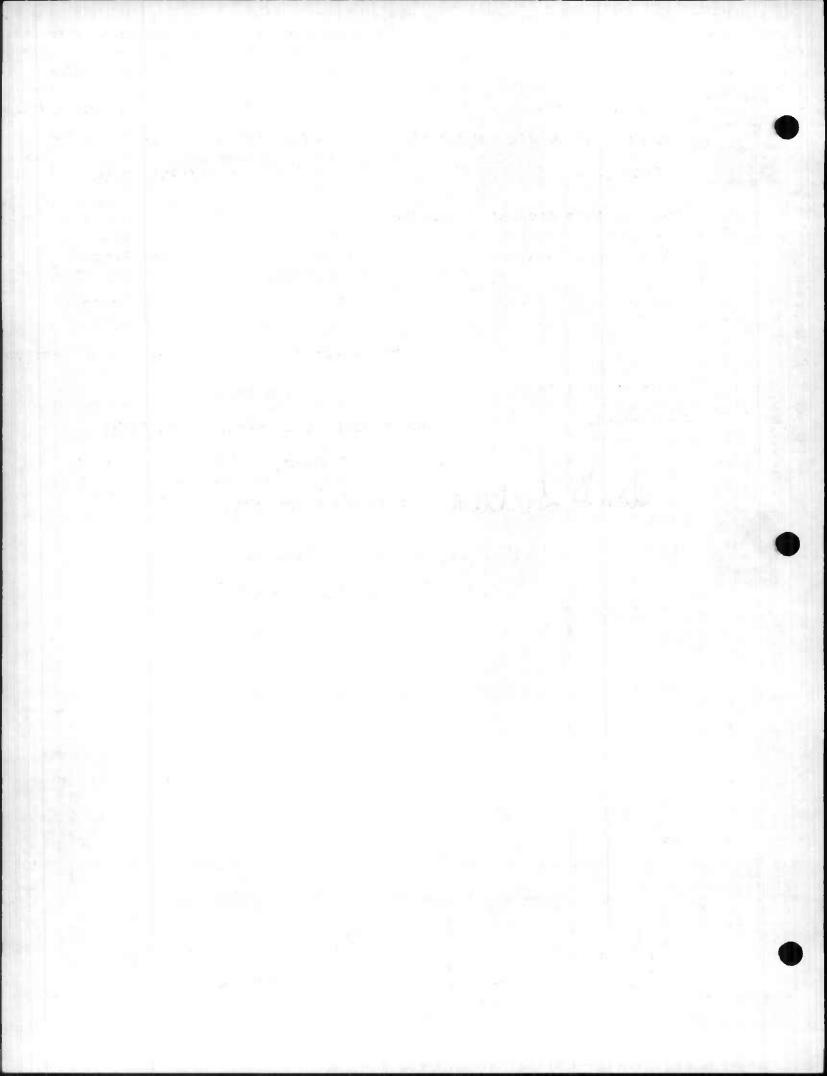
nd address of person who completed causa of daath (Itam 23a) (Type, Print)

litauji

Hospital. Nork

32. Pegistrar's Signatura

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

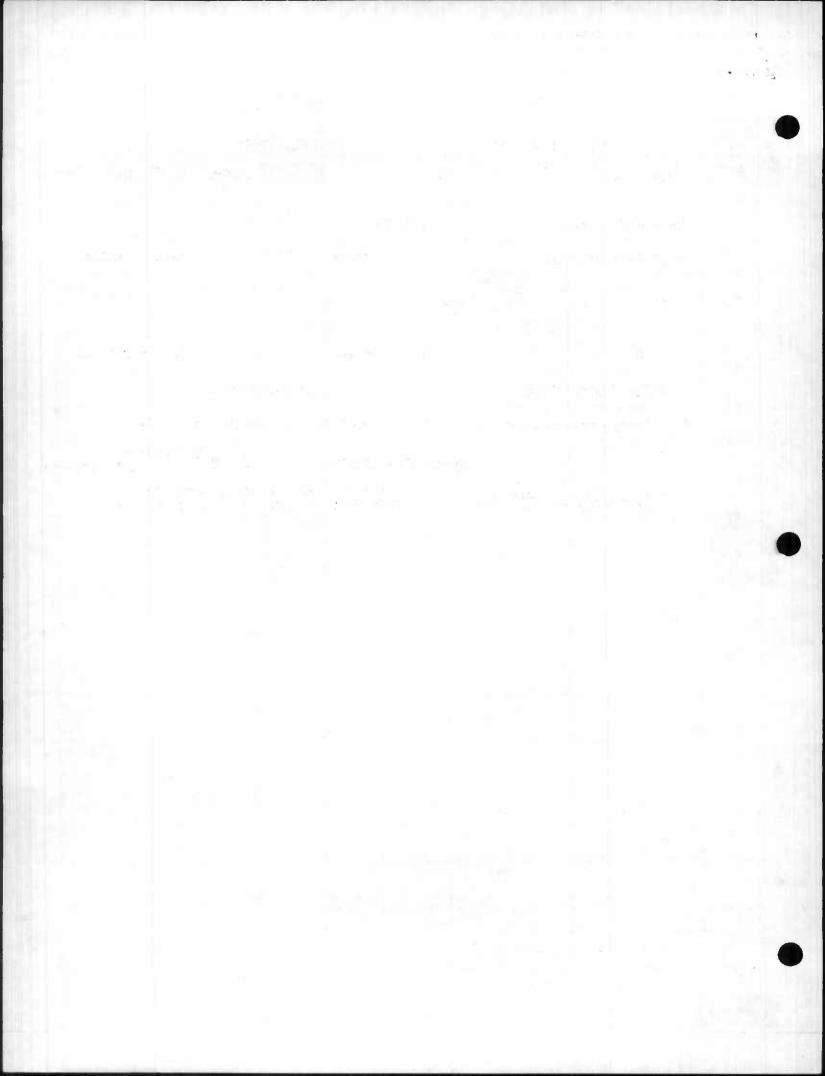


State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Deeth **Physician** Month STANTON WINE 8:40 pm JANUARY /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** N/A Good Samaritan Hospital Baltimore | Months | Deys | Hours | Min. | September 2,1920 6. Sax 1 M M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Yrs Director 233-26-9940 West Virginia Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location h end Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinat must be notified a 10d. Inside City Limits 1 X Yes 2 □ No Director Baltimore Maryland N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? United States 21214 Funeral 5010 Grindon Avenue 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amaricen Indian, Bleck, Whita, atc. 72 hours efter 1 X Yas 2 No If Yes, Give 1942 Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕱 No Specify: White P 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 8 s 1 end 2 should be filed w Health end Mental Hygier tem 27 is marked other ti 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumame) Be Margaret Queen 2 Charles Edward Wine 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 Depertment of Health el Important: If item 27 is any injury or other tra Baltimore, MD 21214 Mrs. Brenda Parrish/Daughter 2502 Albion Avenue 20b. Place of Disposition (Nama of cemetery, cremetery or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cramation 3 ☐ Removel from Stata Enterprise 4 ☐ Donation 5 ☐ Othar (Specify) 2/6/98 Enterprise Cemetery West Virginia 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Leonard J. Ruck Funeral Home, Inc. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not antar tha moda of dying, such es cardiac or respiratory arrest, shock, or heer feilure. List only one ceuse on each line. Approximata Interval Between Onset and Deeth Physician /Medicai Immediate Ceuse (Finel disease or condition resulting in deeth) Schemic Cardiomyopathy Examiner Due to (or es a consequence of): Examiner Renal Failure certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated avents resulting in death) Lest Due to (or as a consequence of): and ettending physician a for use es the buriel-Box 68760 br ain ischemic Physician/Medicai Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the undarlying ceusa givan in Part I. Division of Vital Records, P.O. the 23b. Did tobacco use contribute to the cause of death? signed by t TNYes 2 No 3 Probably 4 Unknown Vascular Disease Teripheral Completed by 24a. Was an autopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? peen s hes page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 2 1 Yes 25 No 1 Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After 1 Naturel 5 Pending efter death. Director: Aft 1 Tes 2 No investigation 2 Accident 6 Could not ba 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) é 4 Homicide 24 hours efter Funeral Dire-letely filled in b the Hospital Medicai 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuse(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and mannar stated. within 2 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number P 11389 MD JANUARY 1311 1998 30. Name and address of person who completed cause of death (Item 23e) (Typa, Print) HOSPITAL ALHARIRI MD - GOOD SAMARITAN JIHAD 31. Dete filed (Month, Dey, Yaar) 32. Registrer's Signature 0 2 1998 FEB Ma Davidson Registrar

DHMH 16 Rav 6/95



98-0468-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene, YOHANNIS A. Item 6 Per PH Film G756 2-2-98 rja WONDIN Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) JANUARY 31, 1998 **Physician** Wondin Yohannis 04:20 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 300 EAST BALTIMORE STREET BALTIMORE If Under 24 Hrs. if Under 1 Yaar Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** 18 M 20 F Months Days Hours Min 217-49-4745 Yrs. 33 Ethiopia Director Usuet Residence of Decedent the Meryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Battomore 1 Yas 2 No MD Directo 7 is marked other than "naturel", or Items 23a or 28a-f treumatic event, the Modical Exampler must be notified 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21223 Ethiopia Lombard 902 Peges 1 and 2 should be filed within 72 hours efter deeth sent of Health and Mental Hygiene.
Int: If item 27 is marked other than "naturel", or Items 23.
Iny or other treumetic event, the Mental Example mainty or other treumetic event, the Mental Example mainty. Funeral 14. Race - Amarican Indian, 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-tf Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11 Maritat Status Black, White, etc. 1 Yes 2 No If Yas, Give Year or Datas: 1 Nevar Marriad 2 Married 1 BYes 2 No Specify: Ethiopian altimore, Maryland 21215-0020 Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Granage Farking Elementary/Secondary (0-12) College (1-4or 5+) Parking Attendent College 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middle, Last) Be Unkn Ayele Wondim 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1209 memorial Dr., Atlanta, Gra. TeterA Zewdie 20c. Location - City or Town, State 110010 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition Important: If it any injury or o once. 1 Burial 2 □ Cramation 3 □ Removal from State Debre Tabore, permit. Pege Department of Debre Tabore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Sarvice Licensee 22. Nama and Address of Facility 1101 E. North Ave Karen m. March F. H. EAST 23a. Part1. Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Intervel Batween Onset and Deeth **Physician** /Medical tmmediate Cause (Final disease or condition resulting in deeth) Multiple quashot wounds Examiner Due to (or as e consequence of): Examiner physicien end the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in daath) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) ettending ph for use es t signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed After this certificete hes funeral director, page 2 1. Yes 2 □ No 1 2 Yes 2 □ No ai or Attending Physician: The safter death.
I Director: After this certificated in by the funeral director, pages of the present of the safter of the safte 25. Was case referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE 1 No 2 No Certification: To 27. Manner of Death 28e. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred Found 3:50 1 Naturet 5 Pending 1 Yes 2 M No investigation Subject was shot

281. Location (Street and Number or Rural Route Number,
City or Town, State) 300 East Baltimare 2 Accident 1-31-98 6 Could not be determined 3 Sulcide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 M Homicide To the Hospital or A within 24 hours after To the Funarel Direcompletely filled in b Parking Garage office Baltimere, City, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Madical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signetura and titla of certifie OCME JANUARY 31, 1998

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Strphen S, 6
31. Dete filed (Month, Day, Year)

MAN

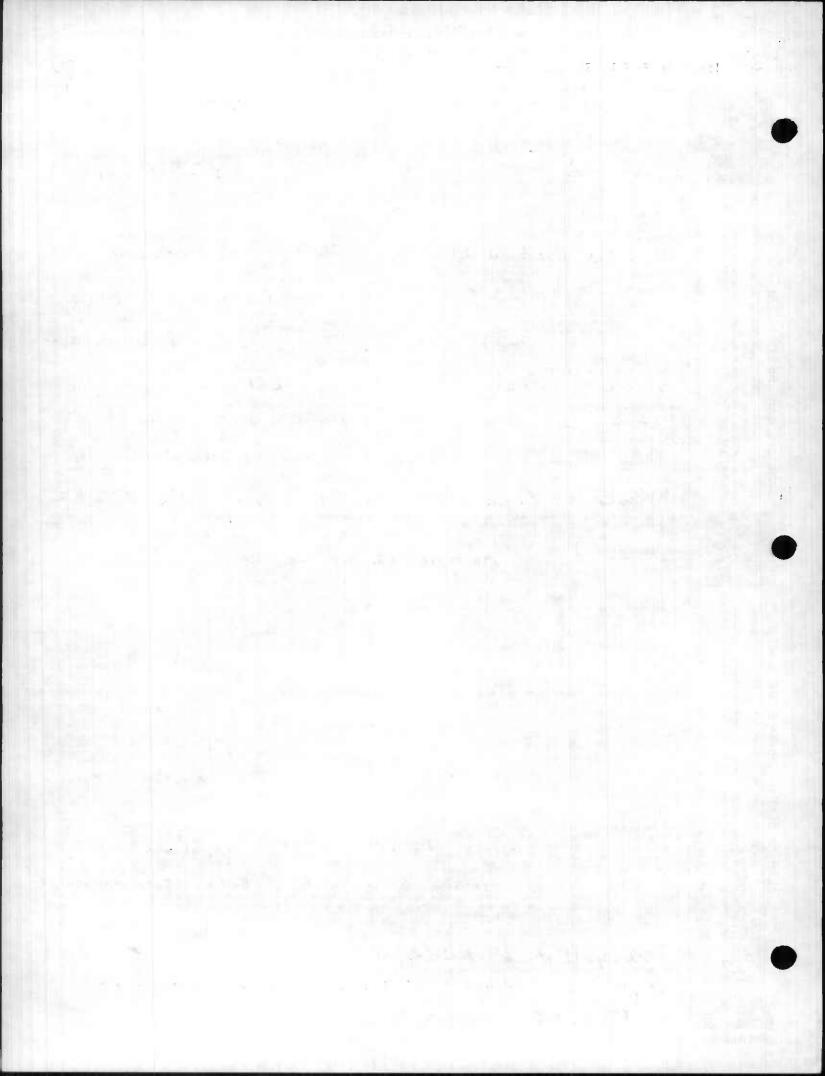
30. Name end address of person who completed cause of deeth (Item 25a) (Type, Print)

Radentz, III

111 Penn Street, Baltimore, Maryland 21201

State Registrar

FEB 0 2 1998 Julia Davidson Randel



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene G Item 10e, 20c Per FH Film G756 2-2-98 rja Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth 3. Tima of Death **Physician** Month Mary ward 5:32AM Jan /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Northwest Hospital Center Baltimore If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Numbar 6. Sax 7. Age (In yrs. last birthday) Birthplece (Stata or Foreign Country) **Funeral** 1DM 2DF 219-16-2583 75 Maryland Director Usuel Residence of Dacadant with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Maryland Baltimore Pikesville 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2 Ivanhoe Olace Place United States 21208 death Funeral 12. Was Dacedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-lt Yes, specify Cuben, Maxican, Puarto Rican, etc.) 11. Marital Status 14. Race - Amarican Indian. permit. Pages 1 and 2 should be filed within 72 hours effer of Depertment of Heelth and Mental Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Evant Black, White, etc. 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: þ Specify: white 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grade completed) 16e. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementary/Secondery (0-12) Collega (1-4or 5+) homemaker own home 17. Fether's Nema (First, Middla, Last) 18. Mothar's Name (First, Middle, Malden Surnama) Be Susan Blanche Buckman Hubert L. Kent 19a. Intermant's Name/Raletlonship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Linda Waring, Niece 208 S. Paradise Avenue Catonsville, MD21228 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other p 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from State Meadowridge Memorial 2/3/98 Doesey, Maryland 4 □ Donation 5 □ Othar (Specify) Dorsey 21. Signature of Funeral Service Licens Ambrose Funeral Home, In 1328 Sulphur Spring Road Arbutus yland 21227 Maryland Part 1. Enter the disaasa, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death Physician /Medicai Immediete Ceuse (Final Pseudomonas DNEUMONLOW ank now diseasa or condition rasulting in daath) Examiner sician and bunal-transit Sequantially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Diseasa or Injury that initiated events resulting in daath) Last certificete be axecu PolyOknowdritis with BRONChietasis wirnown attending physician for usa as the bunal Box 68760. Physician/Medical signed by the all d be deteched for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 12 Hiknown Division of Vital Records, by 24b. Were autopsy tindings evailable prior to completion of cause of daath? 24a. Wes an autopsy performed? Completed certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yas 2 No 1 Impatient Certification: To 2 ER/Outpatiant 3 DOA this 28c. tnjury at Work? : After t 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 5 Panding Invastigation 1 PNaturel s after death.

I Director: After death of the further of the furt 1 Yas 2 No 2 Accidant 6 Could not be 3 Suicida 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, tarm, streat, tactory, office building, atc. (Specify) 4 Homicida ò Hospital of 24 hours at Puneral D 1 🖰 Cartifying Physician: To the best ot my knowledga, daath occurred at the time, data and place, and dua to tha causa(s) and mannar as stated. 29a. Certifian Medical 2 Medical Examtner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the causa(s) and menner steted. (Check only one) To the Within 2 29b. Signetura and title of certifie 29d. Dete signed (Month. Dev. Year) 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

NORTHWEST HOSPITAL CENTER 5401 OLD COURT Rd RANDALISTOWN NO. 21133

Registrar

State

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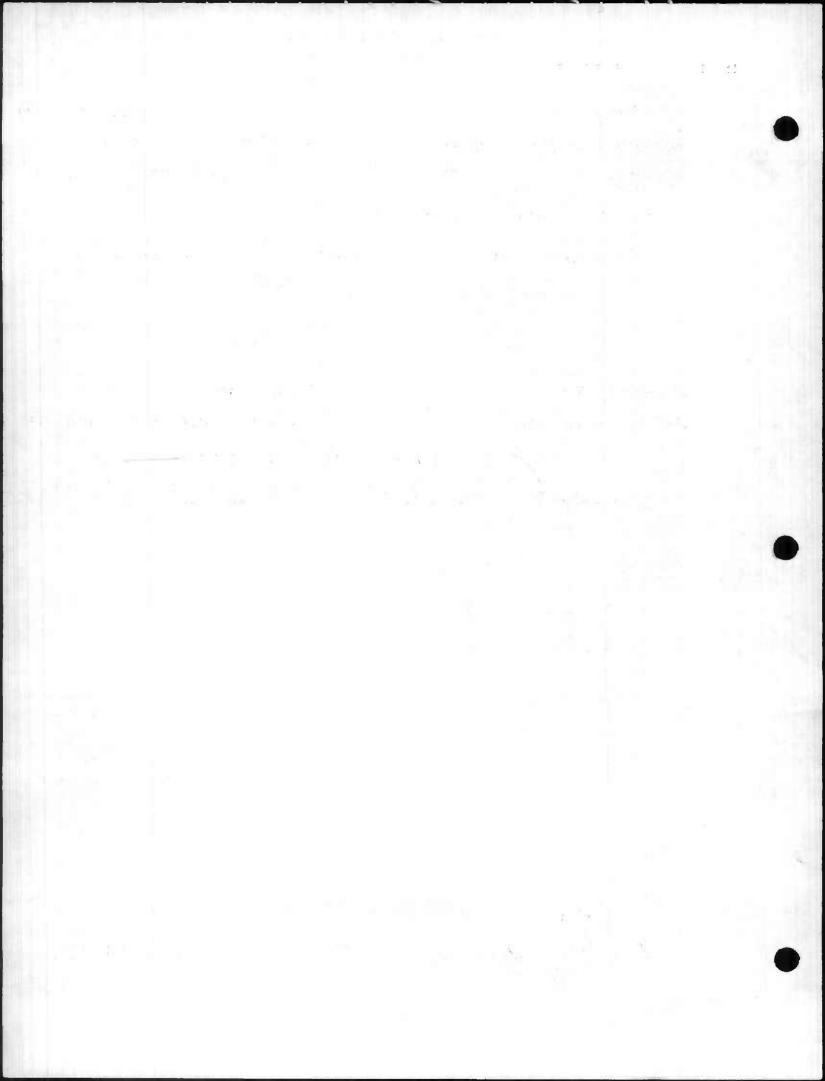
31. Data filad (Month, Dey, Year)

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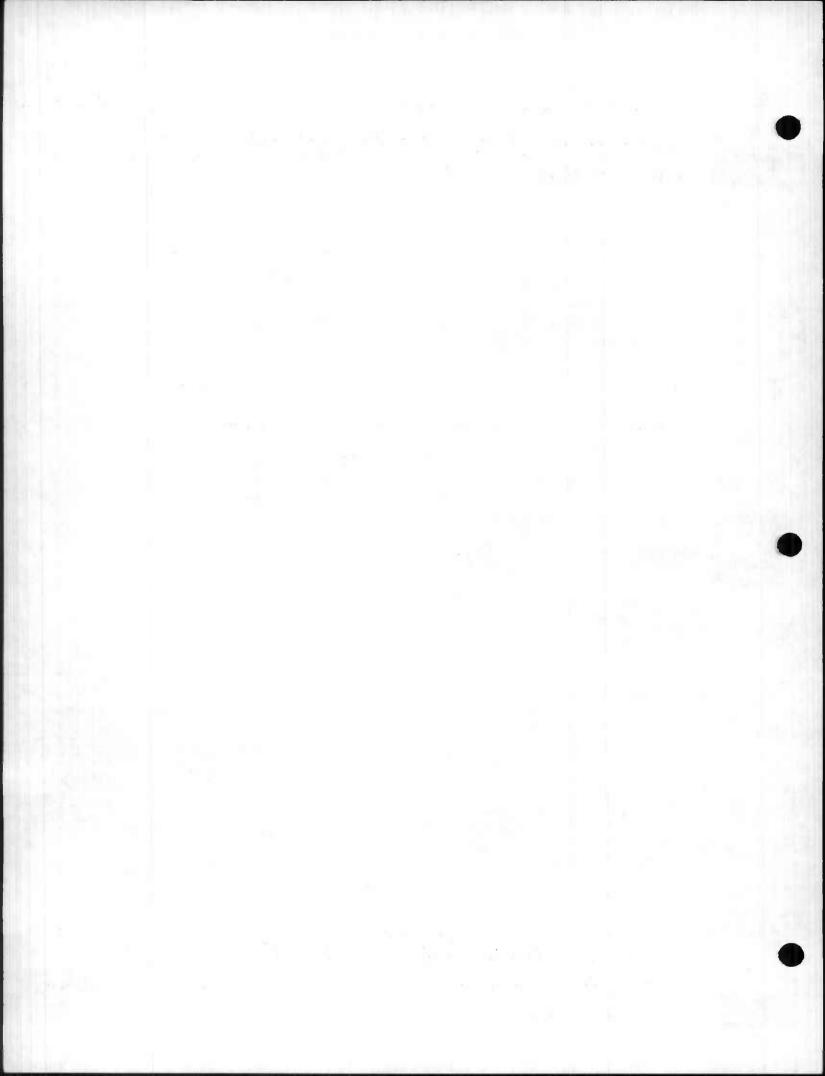
32. Registrar's Signeture

Vilia Davidson-Randell



State of Maryland / Department of Health and Mental Hygiene

8-11				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ficate of	Death		Reg. No. 9	3 02631
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, La WIND E 4a. Facility Neme (If not institution, glv UNIV OF W	RINEST	WAH	Kin	vs 5	1. 4b. City, Town, or Li BAL HMO/C	2. Dete of De Month / coation of Deet	Dey 21	Yeerg8 3. Time of Deeth 3:58pl of Death hmune city
Funeral Director		5. Social Security Number 6. S 216 - 84-4768 Usual Residence of Decedent	ex M 2□ F	(In yrs. last bir		Under 1 Year ionths Days		8. Date of Bir (Month, De 6/20/1	ly Year)	9. Birthplace (State or Foreign BALTIMORE, MD.
show		10e. State 10b. County		10c. City, Tow	n or Locati	on				10d. Inside City Limits
tha Ma 28a-f s	ctor	MARYLAND		BALT	IMOR	Ε				1 X Yes 2 No
3a or 2	ol Dire	10e. Street end Number 2516 N. ELLAMONT	STREET			10f. Zip Code 21216	5		10g. Citizen of V	What Country?
urs a	by Funeral Directo	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 W N If Yes, Give Year or Dates:				Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Blac	e - American Indien, ck, White, etc. AFRO AMERICAN
72 ho	Completed	15. Decedent's En (Specify only highest gra		16a.	Decedent	's Usual Occu	pation during most of work ed)	ina	16b. Kind of B	usiness/Industry
vithin na. han •	mple	Elementery/Secondary (0-12)	College (1-4or 5	+)		NOT use retire NAGER	ed)	9	MCDONA	LD CORP.
be filed v ntal Hygie of other t event, th	00	17. Fether's Neme (First, Middle, Last,)		ירויו	MAULI	18. Mother's Nam	e (First, Middle		
	To Be	WILLIAM E. WATKIN					FRANCE		ATKINS	
d 2 should th and Mar 7 is marke traumatic	-	19a. Informent's Name/Relationship (19b	. Mailing A	ddress (Stree	at end Number or Rur			State, Zip Code)
and 2 taith a 27 is er tra		WILLIAM E. WATKIN	IS SR. FATH	ER 25	16 N	.ELLAMO	ONT STREET	, BALTI	MORE, M	ARYLAND 21217
Department of Heali Department of Heali Important: If Itam 2 any injury or other ance.		20a. Method of Disposition 1 Neurial 2 Cremation 3 4 Donation 5 Other (Specification)	y)		ry, cremete	on (Name of ory or other ple EMETER)		Date /26/98		City or Town, State RE, MARYLAND
permit. Pa Departmar Important: any injury once.		21. Signature of Funeral Service Licer EST	EP				HERS FUNE			LAND 21217
tificata be ig physicia as tha bur	an/Medical Examiner	23a. Part1. Enter the diseese, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting In death) Last	b. Se	psis Due to (or es a of Due to (or as a of Due to (or as a of	consequer	nce of):				Approximate Interval Between Onset end Death
v requiras that tha daath car bean signed by the attandin should be datached for usa	by Physician/	Part II. Other significant conditions of	ontributing to death bu	t not resulting Ir	n the unde	rlying cause g	iven in Pert I.		tobacco use co	ntribute to the cause of death? 3 Probably 4 Unknown
law requiras as bean sign 2 should be	Completed by							24a. Was	s en eutopsy ormed?	24b. Were eutopsy findings evailable prior to completion of cause of deeth?
siclan: Tha law cartificata has b lirector, page 2 s	Con							10	Yes 2□No	1 ☐ Yes 2 No
Physiclan: this cartific ral director,	Be	25. Was case referred to medical examiner?	Hospital: 1			0	26. Plece of Deet	h (Check only	one)	
ding Phy h. Aftar this funaral o	Certification: To								denca 6 Oth how injury occur	
s after death. I Director: After id in by the funer	Sertific	3 Suicide 6 Could not b determined	e 28e. Placa of Inju building, etc.	ry - At home, fa . <i>(Specify)</i>	rm, street,	factory, office		28f. Location (City or To	Street end Numb wn, Stete)	per or Rurel Route Number,
To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: complately filled in by the	Medicai	29a. Certifier (Check only one)	ysicien: To the best of niner: On the basis of and manner stat	examination and	, death oc d/or invest	curred at the t igation, In my	ime, date and place, opinion, death occur	and due to the ed at the time,	ceuse(s) end me date and place,	enner es steted. end due to the cause(s)
To the within To the compl	Me	29b. Signature end title of certifier MICHULL A	Ceamar		Olen	4)9c. Licen	1775		1/21/	g (Month, Dey, Yeer) 98
Stat Registra		30. Name and eddress of person who MUNICHE A 31. Dete filed (Month, Dey, Year) FEB 0 2 1	KAMAN	ath (Item 23e) WWWELL r's Signature	Type, Prin	F MARY!	(AN) MEGER	Bysten	225 G	PEENEST BALLAD.



PLANT ENGINEER

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death JANUARY 1998 2:55 P.M. BURT BERNARD WILLIAMS 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death MERCY HOSPITAL BALTIMORE NA 6. Sex 1 2 M 2 □ F If Under 1 Yeer if Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Days Yrs 52 MD JUL 27 1945 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 1347 MARTIN DRIVE 21229 USA 12. Was Decedent Ever in U,S. Armed Forces? ↑ Yes 2 No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 XNo Specify 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilega (1-4or 5+)

MARY

10e. Street and Number Funeral by

5. Social Security Number

10a State

MD

218-44-1795

Usuai Residence of Decedent

Elamantary/Secondary (0-12)

12th

10b. County

NA

Director Completed 17. Father's Name (First, Middle, Last) Be

Physician

/Medicai

Examiner

Funeral

Director

the Maryland

r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at death

filed within 72 hours aftar Pages 1 and 2 should be filed within ant of Health and Mantel Hygiane. Int: If Item 27 is marked other than ity or other treumatic event, the Mantel or other treumatic event, the Mantel or other treumatic event, the Mantel or other treumatic event, the Mantel or other treumatic event, the Mantel or other treumatic event, the Mantel or other treumatic event, the Mantel or other treumatic event, the Mantel or other treumatic event, the Mantel or other treumatic event. permit. Paga Depertment of Important: If any injury or

Physician /Medical

Examiner

burial-transit physician the 88 for usa be dateched paga 2 should After this funeral 24 hours after death. Funeral Director: A tha

Tha law requires that the death cartificeta be executed

Box 68760,

P.O. |

Division of Vital Records,

or Attending Physicien:

Hospital

Examiner Physician/Medicai ρV Completed Be

Certification: To Medical

BUSTER J. WILLIAMS 20a. Method of Disposition 21. Signature of Funerel Service Licenses land immediate Cause (Final disease or condition rasulting in death) 20 No 1 Yes 27. Mannet of Death Naturai 2 Accident

Sequentielly list conditions, if any, leading to immediate ceuse. Entar Undarlying Causa (Disaasa or Injury that initiated events resulting in death) Last Part il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 25. Was cese referred to medicel examiner?

Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Dey Year) 5 Pending investigation 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 29a. Certifier

29b. Signeture and title of certified 3

28c. injury at Work?

Othar: 4 Nursing Home

St PNI Balt mes

1 Yes 2 No

29d. Date signed (Month, Dey, Yeer)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 4077 (List bory

31. Date filed (Month, Day, Yaar)

(Check only one)

32. Registrar's Signature

Due to (or es e consequence of):

Registrar

complataly

within 2 To the

19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 1347 MARTIN DRIVE HELEN WILLIAMS - WIFE BALTO., MD 20b. Piace of Disposition (Nema of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) GARRISON FOREST VET. CEM.2-2-98 Owings Mills, 22. Name and Address of Fecility Wm. C. March Funeral Home West, Inc. Wa 4300 Wabash Ave. Balto., 21215 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Batween Onset end Death Intic Colon Concer Maron Due to (or as a consequence of) Due to (or as a consequence of):

> 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

TRIGEN CO.

18. Mother's Name (First, Middle, Maidan Sumame)

WILLIAMS

24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed?

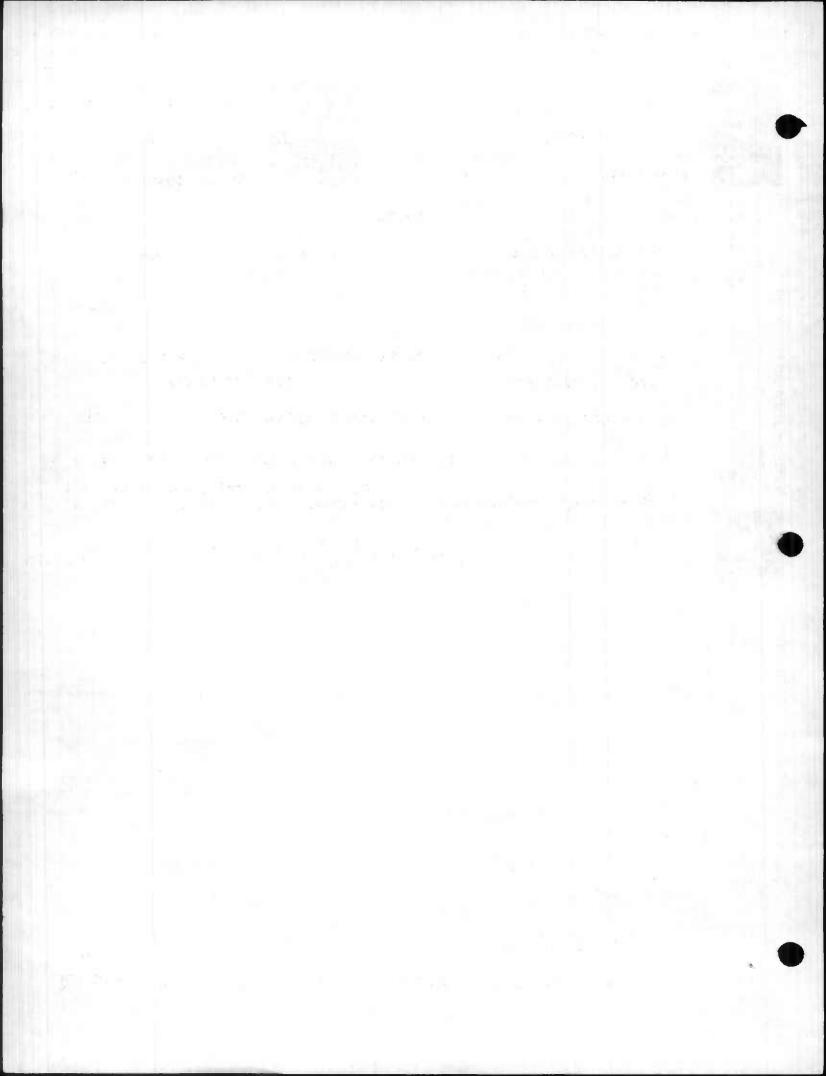
1 ☐ Yas 2 ☐ No 26. Place of Death (Check only on TELLA MARIS AT MERCY 5 ☐ Residence 6X Other (Specify) HOSPICE

Certifying Phyaician: To the bast of my knowledge, daath occurrad at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medicel Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the tima, date and place, and due to the cause(s) and manner steted.

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred



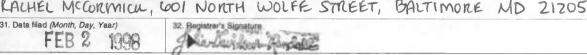
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death WHITE Month **Physician** BEATRICE 1998 10:42 A.M. JANUARY /Medical 4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Dey, Year) **Funeral** 1□M 2□F XX Months Deys Hours Yrs. 217-24-2487 Director 71 07-25-26 Md. Usual Rasidanca of Decedent the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at 1 ¥ Yas 2 □ No Director Md. NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? ŏ 238 21205 USA 921 N. Lakewood Avenue Funerai or items 12. Was Dacedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ ★o If Yas, Giva Wes Decedant of Hispenic Origin? (Spacify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Navar Marriad 2 Married 21215-0020 1 Yes 2 No Spacify: Specify: Completed by 3 Midowed 4 □ Divorced Black natural 16a. Dacadent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Dacadant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Hygiena. College (1-4or 5+) Elamantary/Secondary (0-12) Domestic various trade 9th Grade Na Baltimore, Maryland 17. Fethar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumama) in and Mantal h Be Gertrude Coleman 0 William Purnell 19a. Informant's Nama/Relationship (Typa, Print) 19b. Malling Address (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 21239 nt of Haalth a 1178 E. Northern Parkway Baltimore, Marylaho other LaVera Gundy 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State Department of Important: If any Injury or 4 □ Ponation 5 □ Othar (Specify) Garrison Forest VA Cem.02-04-98 Owings Mills, e of Funeral Service Licenses 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue At 1. Entar tha diseasa, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiretory errast, nock, or haart failura. List only ona causa on aach lina. Approximata intarvat Batween Onsat and Death **Physician** /Medical Immadiata Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE diseesa or condition rasulting in death) **Examiner** EXACER'BATION Dua to (or as a consequenca of): The law requires that the death cartificate be executed Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Ceusa (Disaasa or Injury that initiated avants rasulting in death) Last and burial-tran Dua to (or as a consaquence of): P.O. Box 68760, physician Physician/Medicai for use as the Dua to (or es e consequança of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? signed by TYPES 2 No 3 ☐ Probably 4 ☐ Unknown DISEASE CORONARY ARTERY of Vital Records, þ 8 24b. Were autopsy findings aveilable prior to complation of cause of death? Completed 24a. Was en eutopsy peen HYPERTENSION 1 Yas 2 No ANTHRITIS 1 ☐ Yas 2 No certificate IUNEUMATOID Physician: Be 25. Was casa rafarred to madical axaminar? 26. Placa of Death (Check only ona) Hospital: 100 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) P 1 Yes 2 No this s aftar death.

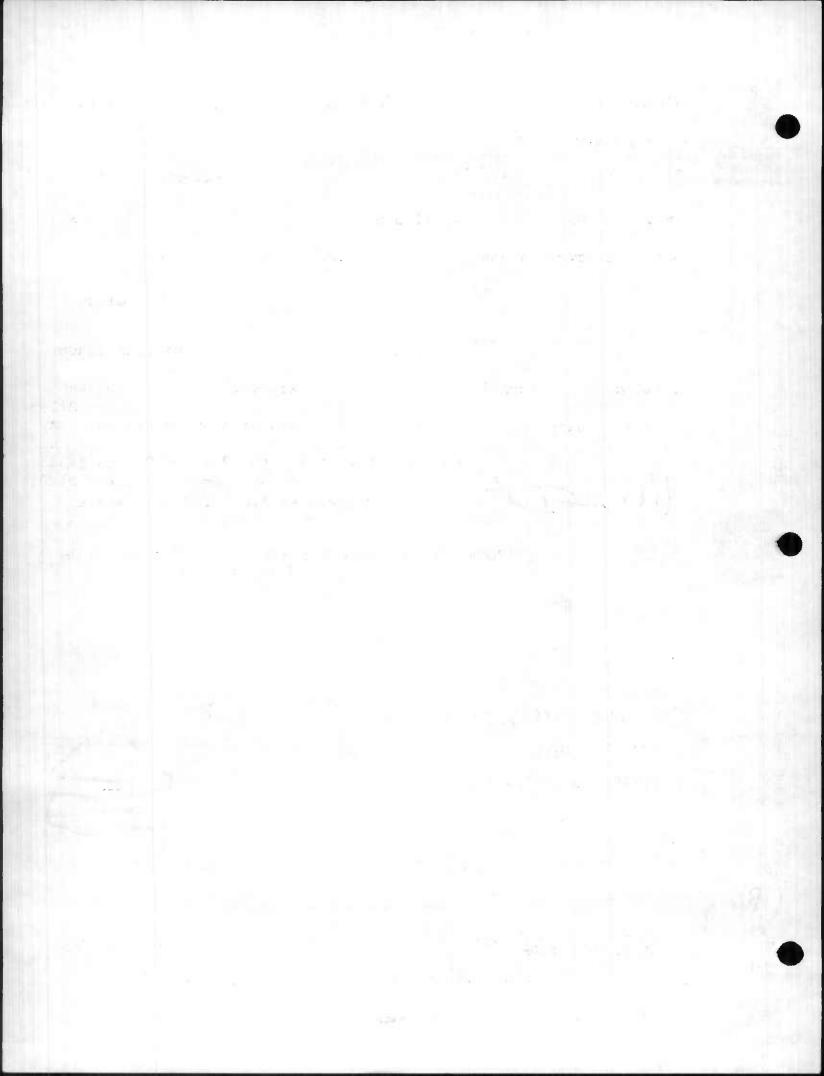
Director: After this d in by the funeral d 27. Mannar of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Division Attending 5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Suicida 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 150 Certifying Physician: To the best of my knowladga, death occurred et tha tima, data and placa, and dua to the causa(s) and mennar as stated.

2 Medical Examiner: On the basis of axamination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to tha causa(s) end mannar stated. 29a. Cartifian Medicai 29b. Signatura and titla of cartifier 29c. Licansa number 29d. Date signed (Month, Dey, Yeer) M'Comus JANUARY 31, 1998 MD RES-000 30. Nama and addrass of person who complated cause of death (Itam 23a) (Typa, Print)

State Registrar

31. Data filad (Month, Day, Yaar) FEB 2





Division of Vital or Attending death. I Director: A To the Hospital or A within 24 hours after To the Funerel Direcompletely filled in b after

28f. Location (Streat end Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Piece of Injury - At home, ferm, straet, factory, office building, etc. (Specify) 3 ☐ Suicida 4 Homicide

29a. Certifier (Check only one)

1 Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as steted. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signatura and titla of certifiar

29c, Licansa numbar

29d. Date signed (Month, Dey, Year)

A Whigh mo

O.C.M.E

JAN. 19, 1998

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

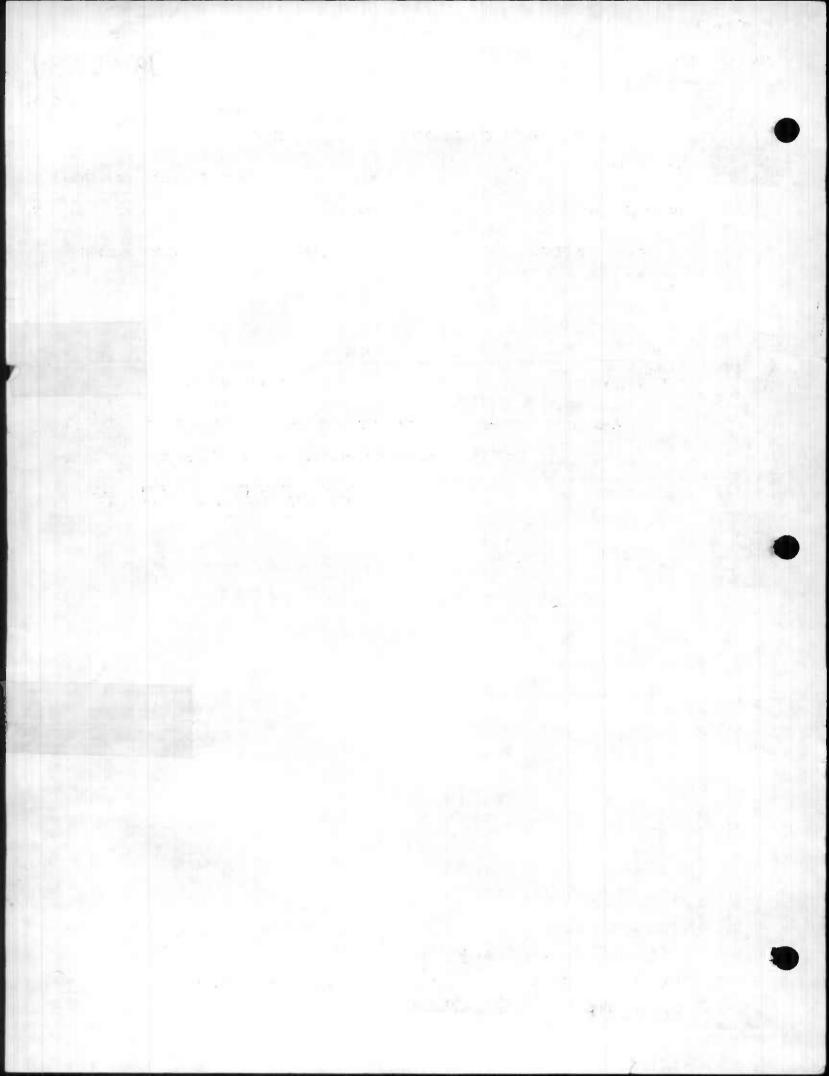
Donald G. Wright M.D.

111 Penn Street, Baltimore, Maryland 21201

State Registrar

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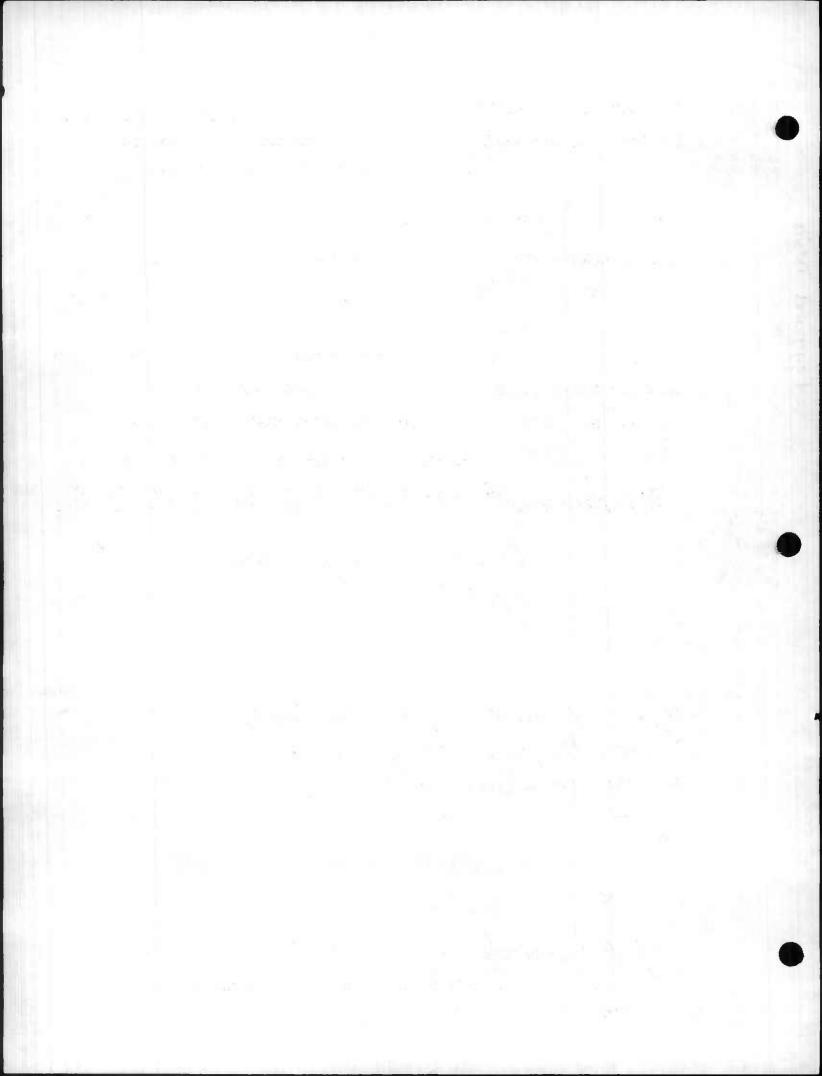




State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** RAYMOND LEWIS ALVIS 4, 1998 4c. County of Deeth /Medical 4b. City, Town, or Location of Deeth 10:28am 4e. Fecility Neme (If not institution, give street end number) **Examiner** The Memorial Hospital Talbot Easton If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) WAY 14,1919 VIRGINIA If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Deys Months Yrs. 216-14-3192 78 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other then "natural", or items 23e or 28a-f shov treumatic event, the Medical Expresse, must be notified at YYes 2□No Directo TALBOT EASTON 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 541 S. AURORA 21601 Funeral STREET USA 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. I ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married Married Maryland 21215-0020 1 ☐ Yes 2 No by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nit. Pages 1 and 2 should be filed within sartment of Health and Mental Hygiene. ortant: If Item 27 Is marked other then "I Injury or other treumetic event, the Mes Elementery/Secondery (0-12) College (1-4or 5+) 3 -0-DRYWALL MECHANIC CONSTRUCTION 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) WILLIAM ABNER ALVIS ROSA WOODCOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MAE ALVIS/ WIFE P.O. BOX 2427, EASTON, MD 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any Injury or SPRING HILL CEMETERY 1-8-98 EASTON, MD 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME CFSP. 23a. Perti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** >20 /Medical Immediate Ceuse (Finel disease or condition resulting in death) ar Examiner Due to (or es e consequence of): Examiner ertensio or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of) P.O. Box 68760 Physician/Medical Due to (or es e consequence of): ate hes been signed by the etter page 2 should be deteched for Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? kemia; Periphera, 1 Yes 2 No 3 Probably 4€ Unknown Division of Vital Records, Completed by 24a. Was en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No pronic 25. Was cese referred to medical exeminer? director, Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) funerel 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident efter deeth Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. Medicai 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ly now 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) HOLLYWOOD, M.D., 607 DUTCHMAN'S LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Pulia Davidson JAN 06 1998

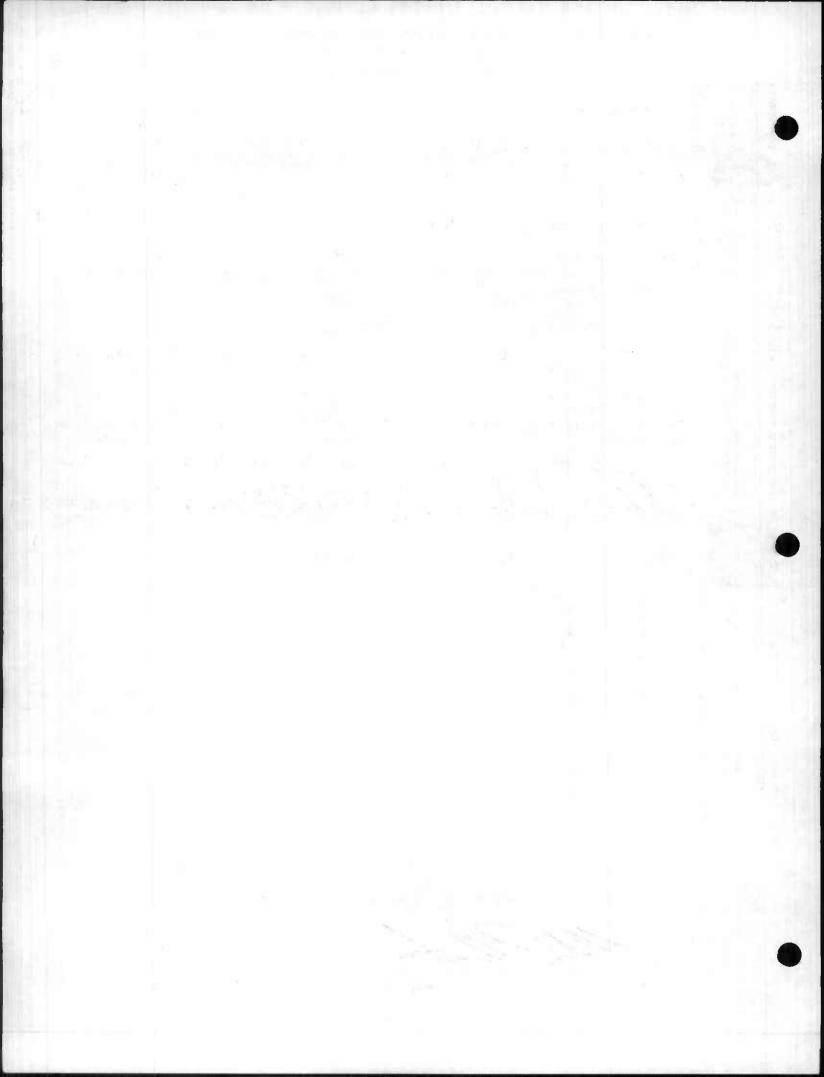
Registrar

Raymond



State of Maryland / Department of Health and Mental Hygiene 9 8 0 2 6 3 6

					Continua	ite of	Death		F	leg. No.			
		1. Decedent's Neme (First, Middle, L	ast)						2. Dete of Dee	th		3. Time of	Death
Physician /Medical		FUCENE C AUTOUTET							Month January			1:00	A.M
nvieur Examir		4e. Fecility Name (If not institution, g	-				4b. City, Town, or Location						
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ineral ector				(In yrs. last bir	Yrs. If Und Months	er 1 Year S Deys		24 Hrs. Min.	8. Dete of Birth (Month, Dey Nov . 2	, Year) 0, 1908	9. Birthpleo Country Minnes	ota	or Foreig
N N		Usuel Residence of Decedent 10a. Stele 10b. County		10c. City, Tow	n or Location							Inside Ci	
office	Director	Maryland Montgo	mery	Silver	Spring							1 Yes	21 JNC
Den		10e. Street end Number	3			ip Code 20903	•			10g. Citizen of United		?	
TO SERVICE	era	1513 Dilston Road	12. Wes Decedent E	ver in IIS				inin? (Sne			ce - American	Indian	
the Medical Examiner must be notified at	by Funeral	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces?		If Yes, sp				cify Yes or No- Rican, etc.)	Specil	ck, White, etc.		
lea l	ted	15. Decedent's E	Education	16a.	Decedent's Us	uel Occu	petion			16b. Kind of B	Business/Indus		
Mad	Completed	(Specify only highest gi	College (1-4or 5	+)	Decedent's Us (Give kind of w life. DO NOT	vork done use retire	dunng mos ed)	it of worki					
	Co	10	0	Ut	ility (Contr	_			Undergr		ewer	/Wat
d other event,	Be	17. Felher's Neme (First, Middle, Las	st)				18. Moth	er's Name	(First, Middle,	Meiden Sumai	me)		
marked imatic e	P	John Ahlquist							Koivist				
e 2		19e. Informent's Name/Relationship			. Meiling Addres								201
ther tr		Edward V. Ahlqui:	st - Nepnew		328 Mead			oad,		20c. Location			201
lant: If III		1X Burial 2 □ Cremation 3 I 4 □ Donatiop 5 □ Other (Speed			Disposition (No ry, cremetory or Washir			tery	15000	Adelphi			
any in		21. Signature of Funeral Service Lion	1-A		Hines-	-Rina		uner	al Home		0 1) (T)	20
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene & Amend #7,1/20/98, BMW, Montg. Co. Certificate of Death 1. Decedant's Nama (First, Middia, Last) 2. Data of Death 3. Time of Death Day Year **Physician** Austra E. Albats /Medical January 14, 1998 11:45PM 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring
If Undar 24 Hrs. 8. Data Montgomery 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar 6. Sax 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1□ M 2⊠ F 86 07 Director 220-28-6763 Nov. 30, 1911 Russia Usual Rasidence of Dacadani death with the Maryland 10a. Stata 10b. County 10c. City. Town or Location r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Insida City Limits 1 AYas 2 No Directo Maryland Montgomerv Kensington 10e. Straat and Number 10f. Zlp Coda 10g. Citizan of What Country? 3000 McComas Avenue Funeral 20895 United States 12. Was Decedant Evar in U,S. Armed Forcas? 1 Yas 2 No Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status filed within 72 hours after Hygiena. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yas 2 🖾 No by Yas, Giva Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade complated) 16a. Dacedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona duning most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotiega (1-4or 5+) 12 Retail Sales Bookkeeper other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is merked oth any injury or other traumatic event obtes. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Janis Klava Augusta Millers 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19889 Ridgecrest Square, Ashburn, Virginia L. William Kobler/Son-in-Law 20147 20b. Place of Disposition (Name of cematary, crematory or other place)

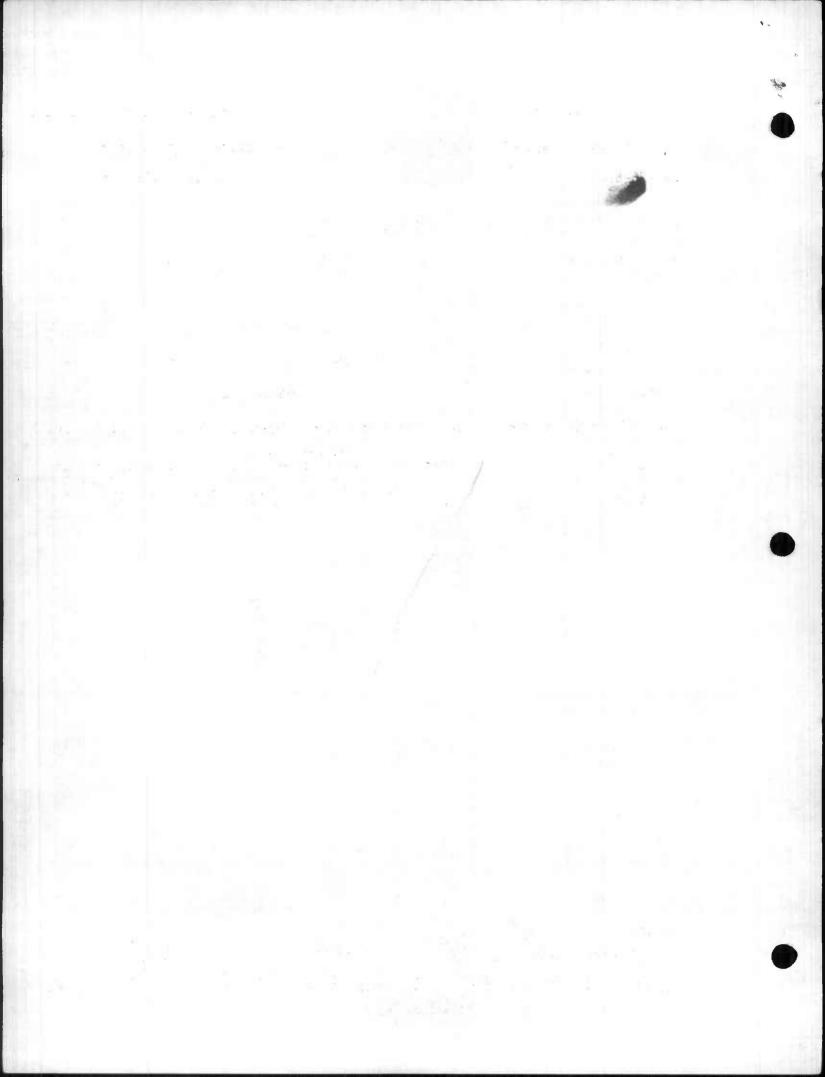
Montgomery Crematorium, Inc. 20a. Mathod of Disposition
1 ☐ Bunai 2 ☐ Cramation 3 ☐ Ramoval from State Data 20c. Location - City or Town, Stata 1998 4 ☐ Donation 5 ☐ Othar (Spacify) Bethesda, Maryland 21, Signature of Funeral Service Licent 22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Bethesda-Chevy Chase, Inc. 23a. Part1. Entar the disaasa, or compilcations that caused that death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Dua to (or as a consequanca of) Physician/Medical Examine The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury attending physician and for use as the burial-tran Dua to (or as a consequence of). Division of Vital Records, P.O. Box 68760 that initiated evants Dua to (or as a consequence of): rasulting In death) Last isigned by the a Part il. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yee by been signature 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy compiation of causa of death? has l page ils certificate I 1 ☐ Yas 2XXNo or Attending Physician: Be 25. Was case refarred to madical axaminar? 28. Place of Daath (Check only one) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 2 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 2 Accidant 5 Pending Invastigation n 24 hours after death. 1 ☐ Yas 2 ☐ No 6 Could not be detarmined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suiclda 28a. Piace of Injury · At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital 29a. Cartifian Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and titia of certifian 29d. Date signed (Month, Day, Year) 29c. Licansa number

complated cause of seath (Itam 23a) (Type, Print)

LAGOT AVE

State Registrar 30. Name and addrass of person who



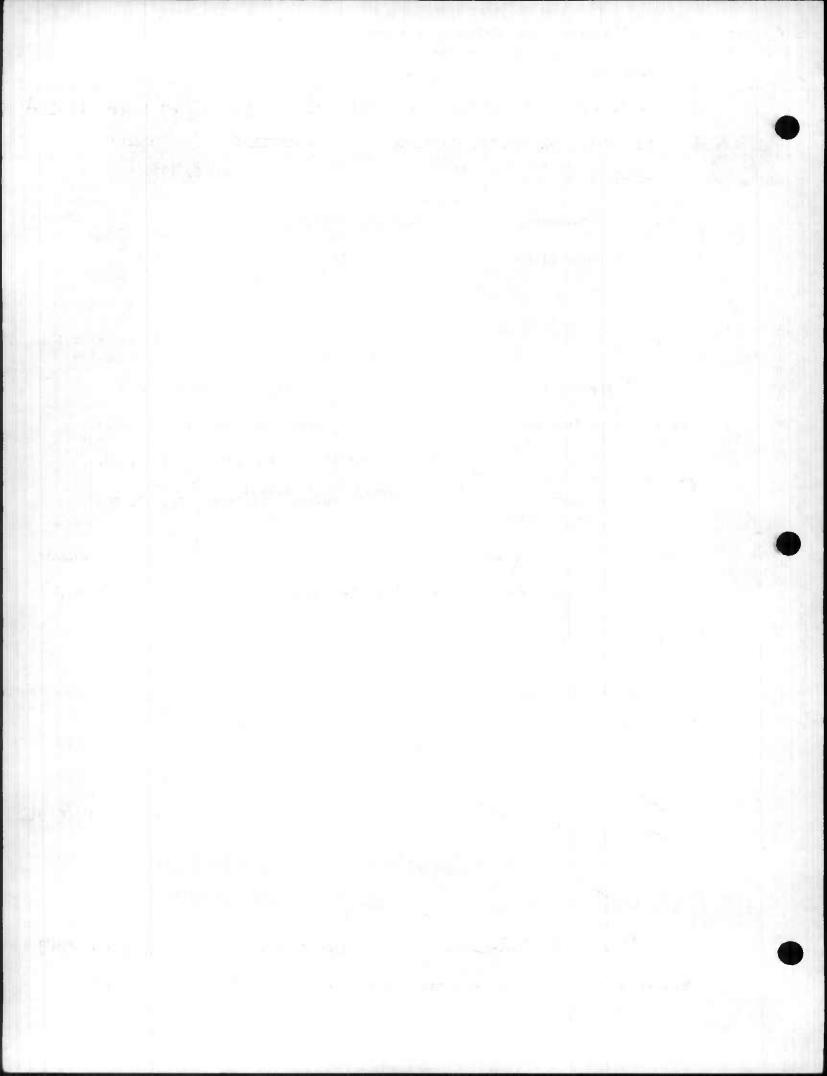
State of Maryland / Department of Health and Mental Hygiene 🌖 🖯

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ABRAMOWIT 115A 1998 Dunuary /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** MONTGOMERY ADVENTIST HOSPITAL ROCKVILLE SHADY GROVE If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. June 6, 1935 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 18 M 2□ F 62 Yrs. Director 058-30-7287 Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryler Department of Health and Mental Hygiene.
Important: If lem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other than the filed permitted to notified a 1 ☐ Yes 2 No Director Montgomery Montgomery Village 10e. Street and Number 10g. Citizen of What Country? 9436 Bethany Place 20886 US Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Raca - Amarican Indian, Black, White, etc. 11. Marital Status 1 ☐ Yas 2 XNo If Yes, Give Yaar or Datas: 1 Never Married 20 Married 1 ☐ Yas 2 XNo Specify: by Specify: 3 Widowed 4 Divorcad White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Wholesale Floral Elementary/Secondary (0-12) College (1-4or 5+) Siupplies 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be 10 Max Abramowitz Learer Fanny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barry Abramowitz/ Son 12686 Brady Place Jacksonville, FL. 32223 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Judean Memorial Gardens 1/18/98 Olney, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sérvica Licensel 22. Name and Address of Facility Direction Edward Sagel Funeral 1091 Rockville Pike Rockville, Md. 23a. Part 1. Entire the disclassic Complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heer fallure. List only one cause on each line. Approximata Interval Betwe Onset and Death **Physician** /Medical Immediate Cause (Final minutes disaase or condition resulting in deeth) Examiner adeno carcinoma sician end buriel-trensit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of) physician streets the buriel P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 0 ed by the et Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed be should be dete Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performad? Completed hes certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certific 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) exammer? 1 Yes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Wother (Specify) HOS PITAL To 2 ER/Outpatient 3 DOA funerai 27. Manner of Death 28d. Describe how Injury occurred Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 2 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 17, 1997 D43083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 MEDICAL CENTER DR. #300 POCKUTUE MD 20850 6850.65 A. SOTOS, MO 32. Registrar's Signature State Jika Tavidan Bandase

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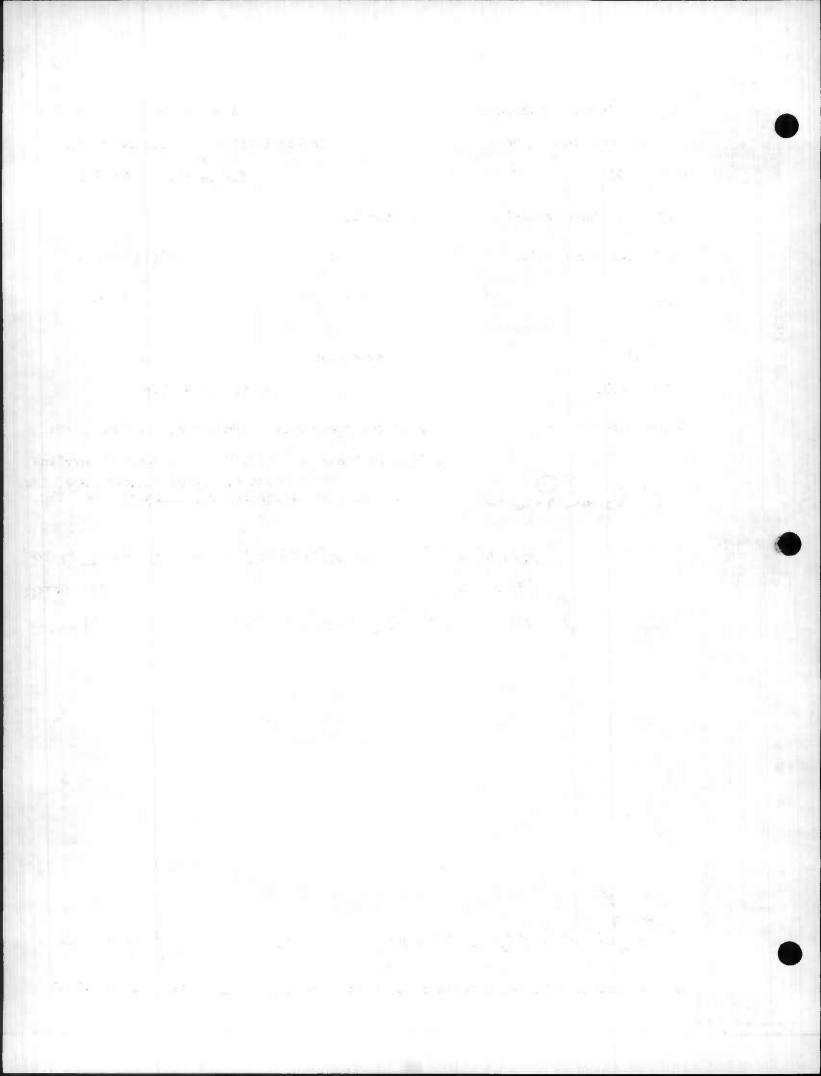
Registrar



State of Maryland / Department of Health and Mental Hygiene

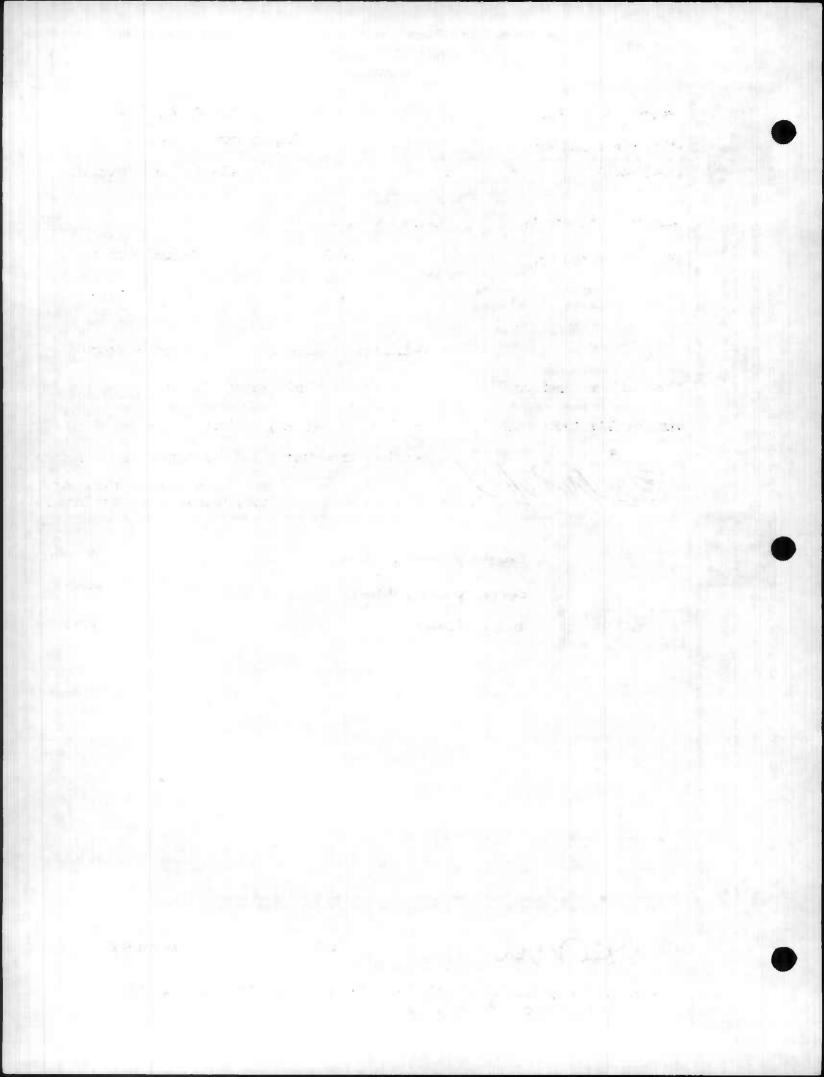
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month OLGA KACHE ADAMSON /19/1998 12:20PM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Villa Rosa Nursing Home Mitchellville Prince George If Under 1 Year 5. Social Security Number If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dev. Yeer) Birthplece (State or Foreign Country) **Funeral** Deys 1□M 2\F Yrs. Director 267-04-6528 Nov 14 1906 Virginia Usuel Residence of Decedent with the Maryland 10a Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits mat be notified at Anne Arundel Director Annapolis 17 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1225 Van Buren Drive 21401 by Funeral United States 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispento Origin? (Specify Yes or No-If Yes, specify Cuban, Mextcen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Haalth and Mental Hygiena. Important: If item 27 is merked other than "natural", or iten any Injury or other treumetic event 1 ☐ Yes 2♥ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0020 1 Yes 2√2 No Specify: White 3€Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Homemaker Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be John Kache Annie Cockerille 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Wayne Adamson (Son) 1225 Van Buren Drive Annapolis, Maryland 21401
Dete 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 1 ☐ Buriel 2 [XCremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Ft. Lincoln Crematory 1/20/98 Brentwood, Maryland 22. Name end Address of Fecility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Line 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. a Advance Chronic obstructive Yulmonary Disland **Physician** /Medical tmmediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Atherosclerofic Heart Disean Box 68760, Physician/Medical been signed by the e should be datached f P.O. Pert II. Other significent conditions confributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? this cartificate Division of Vital spital or Attending Physician: The hours after death.

neral Director: After this cardificate by filled in by the funeral director, pa 25. Was cese referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident Investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical completaly i To the I 290 Alignature and liftle of certifies 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Rakesh Arora, 14300 Gallant Fox Lane Bowie, Maryland 20715(301-262-7800) M. D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 0 1998 Registrar



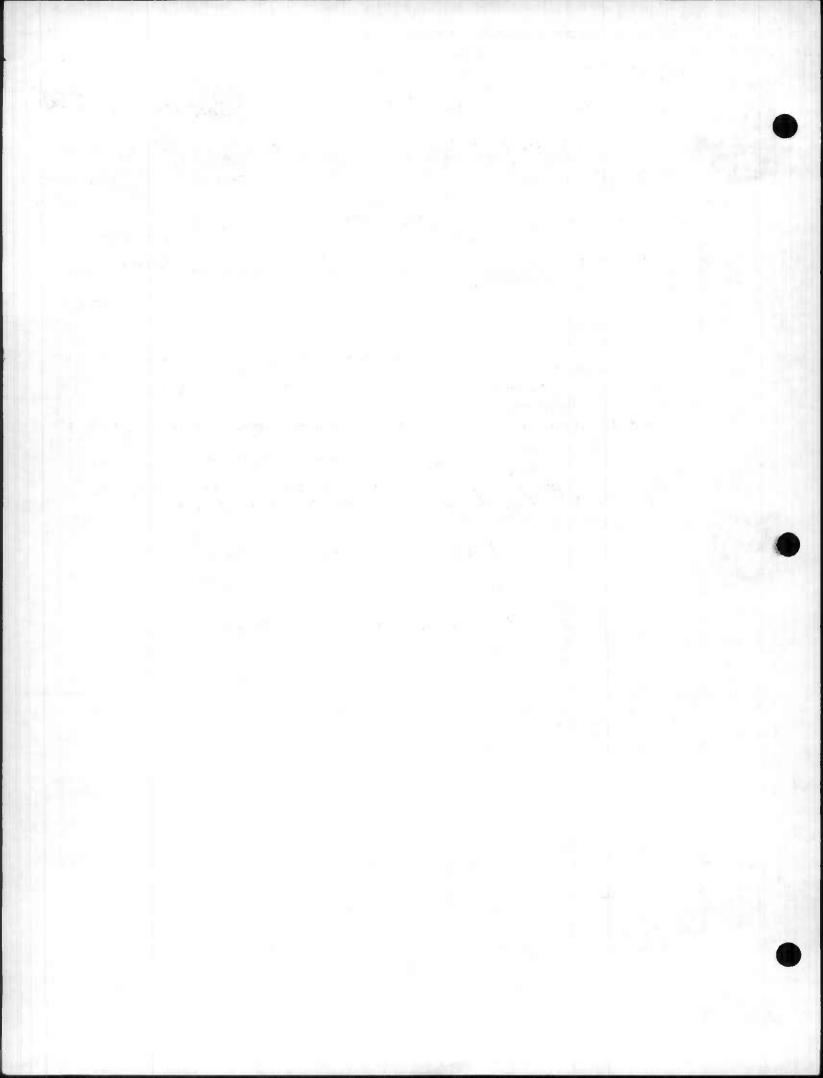
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Mindelcal Examiner Mindelc		Physician	23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications thet caused the one cause on each line.	e death. Do not e	nter the mo	ode of dy	ing, such es cardia	c or respiretory e	rrest,	-	Approximete Intervel Between	
Sequentially list conditions contributing to death but not resulting in the underlying cause given in Pert I. Sequential process of the pr		/Medical	disease or condition	Immediate Ceuse (Final disease or condition resulting in death) e. Cardo pilumany arest								wondy	
Sequentially list conditions contributing to death but not resulting in the underlying cause given in Pert I. Sequential process of the pr	L	je l					1	year					
Cause (Disease or injury indicated events resulting in deeth) Lest Due to (or es consequence of): Due to (or es consequence of): Due to (or es consequence of): Due to (or es consequence of): Due to (or es consequence of): 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy parformed? 24b. Were eutopsy indings eventleble prior to easily part of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy parformed? 25b. Was case referred to medical eventleble prior of cause of death? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes Ye		outed ransil	Sequentially list conditions.	b. corbnar	ue to (or es a cons	equence of):						
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The state of the s	376	hysici the bu	thet initiated events	C	e to (or es e cons	equence of):					0	
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So So So So So So So So So So So So So S		the e	Part II. Other eignificant conditions of	contributing to death but i	not resulting in the	underlying	cause g	iven in Pert I.	23b. Dld	tobacco uae co	ntribute t	o the cause of death?	
Second S	٦	= 60							10	Yes 2□ No	3 Pro	bably 4 Unknown	
25. Was case referred to medical exeminer? Security cords	v requiper should									ev	reileble prior to		
26. Place of Deeth (Check only one) 26. Place of Deeth (Check only one) 27. Menner of Deeth 28. Place of Deeth (Check only one) 28. Injury the Work? 1 Yes 2 No 28. Injury the Work? 1 Yes 2 No 28. Injury the Work? 28.	R	he la age 2							10	Yes 2 No	1[□Yes 2□No	
Comparison of Death Continue	ta	tiffice tor, p	25. Was case referred to medical										
1 Naturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signeture aut the or caminer 29b. Signeture aut the or caminer 30. Neme end a life is of parson who completed cause of deeth (Item 23e) (Type, Print) 29c. License number 29d. Date signed (Month, Dey, Year) 31. Date filed (Month, Dey, Year) 32. Registrer's Signature 29d. California, Maryland 20619 32. Registrer's Signature 33. Registrer's Signature 29d. California, Maryland 20619		Z S D		Hospitel: 1 Inpatient	2 ER/Outpati	ient 3 🗆 [DOA O	ther: 4 Nursing I	Home 5 Resi	dence 6 □Oth	er (Specit	fy)	
28e. Place of Injury - At home, farm, street, factory, office 29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. License number 29d. Date signed (Month, Day, Year) 1 - 24 - 8 30. Neme end add set of the time, dete end place, end due to the cause(s) end menner es steted. 29e. License number 29e. License number 29e. License number 29e. License number 29e. License number 29e. License number 29e. License number 29e. License number 29e.		er th neral		28e. Dete of Injury (Month, Dev Y	(ear) 28b. Time		28c. Inju	ury et ork?	28d. Describe	how injury occur	red		
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29a. Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 29b. Signeture and the of centifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end menner es steted. 29c. License number 29d. Date signed (Month, Day, Year) 1 29c. License number 29d. Date signed (Month, Day, Year) 1 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	Divis	s efter de il Direct ed in by t	determined	e 28e. Place of Injury building, etc. (28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locatic City of C					Street end Numb wn, Stete)	er or Run	al Route Number,	
30. Name and address of parson who completed cause of deeth (Item 23e) (Type, Print) Jeffrey C. Brown, MD, 22576 MacArthur BLVD., California, Maryland 20619 31. Date filed (Month, Dey, Yeer) 32. Begistrer's Signature		Hospi 4 hour Funer tely fill	(Check only 2 Medical Exam	niner: On the basis of ex	caminetion end/or								
30. Name and address of parson who completed cause of deeth (Item 23e) (Type, Print) Jeffrey C. Brown, MD, 22576 MacArthur BLVD., California, Maryland 20619 31. Date filed (Month, Dey, Yeer) 32. Begistrer's Signature		To the To the somp	29b. Signeture and title of certifier			2	9c. Licen	se number		29d. Date signe	d (Month,	Day, Year)	
30. Name and address of parson who completed cause of deeth (Item 23e) (Type, Print) Jeffrey C. Brown, MD, 22576 MacArthur BLVD., California, Maryland 20619 31. Date filed (Month, Dey, Yeer) 32. Registrer's Signature			1 VOO	711			D425	97		1-24.	98		
Jeffrey C. Brown, MD, 22576 MacArthur BLVD., California, Maryland 20619			30. Neme end address of parson who	completed cause of deel	th (Item 23e) (Type	e, Print)							
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		State	31. Date filed (Month, Dey, Yeer)	32. Registrer's	Signature						J.J.		



State of Maryland / Department of Health and Mental Hygiene 8 0264

					Certifica	ate of	Death	Re	g. No.	(a) (a-a)			
Physic /Medi		1. Decedent's Name (First, Middle, Las ELEANOR		ADAI	ns			2. Date of Deeti Month		798	3. Time of Death		
Exami		4a. Fecility Name (If not institution, give	street and number)				4b. City, Town,	or Location of Death	4c. County				
		Southern Maryl	and Hospita	1			Clint	on	Desir	C-			
Funeral	П	5. Social Security Number 6. Se	9x 7. Age (/	n yrs. last birt		ler 1 Year	If Under 24 H	rs. 8 Date of Birth		ce Ge	Orges lace (State or Foreign try)		
Director		194-20-2164	□M 2ĬŬF	84 1	rs. Month	s Days	Hours M	in. (Month, Day,	1913	Nes	w Jersey		
P.		Usual Residence of Decedent						1001912	<u> </u>	I III	w Jersey		
how		10e. State 10b. County		Dc. City, Town						10	Od. Inside City Limits		
a Ma	cto	Maryland St. Ma	ry's	Cali	ifornia						1 ☐ Yes 2 🖾 No		
1 to 20 0	Director	10e. Street and Number			10f. 2	Zip Code		10	g. Citizen of	What Coun	try?		
23a		1157 Hickory Nu	t Drive			21	0659		U.S.	Δ			
r dag	Funeral	11. Marital Stetus	12. Was Decedent Eve Armed Forces?	r in U,S.	13. Was Dec	edent of l	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No-	14. Rac	ck, White,			
permit. Pagas 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Inportant: if item 27 is marked other than "naturel", or items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Examiner must be notified at once.	F	1 Never Married 2 Married	1 ☐ Yes 2 ☐XNo If Yes, Give			X No			Specif				
urei',	d by	3 XWidowed 4 □ Divorced	Year or Dates:				opcony.		Specii	V. V	Vhite		
72 h	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a.	Decedent's Us (Give kind of a	vork done	during most of v	vorking 1	6b. Kind of B	usiness/Ind	ustry		
within ena. than	I de	Elementery/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retire	ed)						
filed within 72 hours at Hygiena. ther than "naturei", or ent, he Medical Exam		12th			Statis	tica	1 Clerk			U.S. Government			
Mental H Merked ot arked ot	Be	17. Fether's Name (First, Middle, Last)	m . 11				18. Mother's N	lame (First, Middle, M	aiden Surnan	ne)			
should be nd Mental marked o	P		Troxel1			_	Emm		Tracey				
nd 2 should be file ith and Mental Hy 27 is merked othe traumatic event		19a. Informant's Name/Reletionship (T						Rural Route Number,					
l and laalth m 27 ther tr		Kermit E. Adams/		23	153 Gr Disposition (A	ey So	quirel L	ane, Calif					
Pagas nant of th		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ I		cemeter)	, crematory of	other pla			0c. Location				
permit. Pagas 1 ar Department of Haa Important: If Item 3 any Injury or other once.		4 □ Donation 5 □ Other (Specify,) F	ort Li	ncoln	Cemet	tery	1/30/1998	rentwo	od, M	ID		
Physician /Medical Examiner	Immediate Cause (Final CONFESONE HEMS FAMILE												
artificata be axecuted ling physician and is as the burial-transit	i Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	b. ISCME	nic	CAR	DIO	MYOR	のライク Strase					
0 0 8	Physician/Medical	that initiated events resulting in deeth) Last Part II. Other algnificant conditions con	Due	to (or es e co	onsequence of):							
tha ache	hys	^ ^			FICIE						the cause of death?		
that ned b	by P	CHRONC RE	- 7	1 Yes 2 No 3 Probably 4 1			ably 4 Unknow						
The law requiras that tha death ata has been signed by the attar page 2 should be detached for t	Completed b							24e. Wes en	eutopsy ed?	eva	re autopsy findings ileble prior to apletion of cause eeth?		
	On							1 ☐ Ye	2 10 No	1 🗆	Yes 2□ No		
icien: The cartificata rector, pag	Be (25. Was case referred to medical examiner?					26. Place of D	eath (Check only one)	1			
	To	1 Yes 278 No	Hospital:	2 ER/Out	patient 3 [OOA Oth	her: 4 Nursing	Home 5 ☐ Resider	ce 6 □Oth	er (Specify)		
g Ph tar th naraí		27. Manner of Deeth	28a. Date of Injury (Month, Day Ye	28b. Ti	me of jury	28c. Inju Wo							
tending P death. tor: Aftar i tha funari	atic	1 Natural 5 ☐ Pending investigation	(month, boy to	/	М		Yes 2□No						
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28f. Location (Street and Number or Rural Route Number, City or Town, State)										
Hospi 24 hou Funer staly fill	edical	29a. Certifler (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of moner; On the basis of exa and manner stated.	y knowledge, minetion and	death occurre for Investigation	d at the ti	me, date and pla opinion, death oc	ce, end due to the car curred at the time, de	ise(s) and ma e and plece,	anner es ste end due to	eted. the cause(s)		
2 5 2 5		20h Signatura and title of contilion	IIII 239 III		2	9c Licens	se number	29	29d. Date signed (Month, Day, Year)				
To the Within To the	Σ	29b. Signature and title of certifier	1/25/58										
To the within To the comple	2	3. Signature and time of certifier	wa			-		1	125/0		Pay, Year)		
To the Comple	M	OKB. Bas	ompleted cause of death	(Item 23a) /T		D3	9909		/ /	18	Pay, Year)		
To the within: To the comple	W	30. Neme and address of person who co	ompleted cause of death	(Item 23a) (T		D3	9909	DN MD	/ /	18	Pay, Year)		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 1152 IRVING ADKINS, JR. lanuary /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** 1 X M 2 □ F 214-30-8846 64 Director AUG.10, 1933 MARYLAND Usual Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Mudical Examiner must be notified at 1 Yes 2 No Director WICOMICO SALISBURY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 0 Items 23a 146 FRANCIS DR. permit. Pages 1 and 2 should be filed within 72 hours after deeth Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any injury or other traumatic event. 21801 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 □ Divorcad WHITE 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 TELEPHONE COMPANY SUPERVISOR 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be IRVING M. ADKINS, SR. **BERTHA** McCREADY 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) STEVEN ADKINS - SON BOX 128B RT.1 LAUREL, DE 19956 20b. Plece of Disposition (Neme of cametery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 X Buriai 2 ☐ Cremetion 3 ☐ Removel from State 5 Other (Specify) 4 Donation SPRINGHILL MEMORY GARDENS 1-17-98 HEBRON, MD 21. Signature of Feneral Servica Licansee 22. Name end Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME SALISBURY, MD 21804 Julno uala 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. **Physician** /Medicai Immediete Ceuse (Final diseese or condition resulting in death) Sudden Cordiai Death Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting In death) Lest Due to (or es e consequence of): Due to (or es e consequence of): for use as Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. ate hes been signed by the page 2 should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy tindings evellable prior to completion of cause of death? 24e. Wes en eutopsy performed? this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 1 Yes 2 No 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident ofter death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide

or Attending Physician: death. Hospital 24 hours e

completely within 2 To the

Medical

31. Dete filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

alum JANE A. GULL, MO

29c. License number 195995

12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and plece, end due to the ceuse(s) end menner stated. 29d. Date signed (Month, Dey, Yeer)

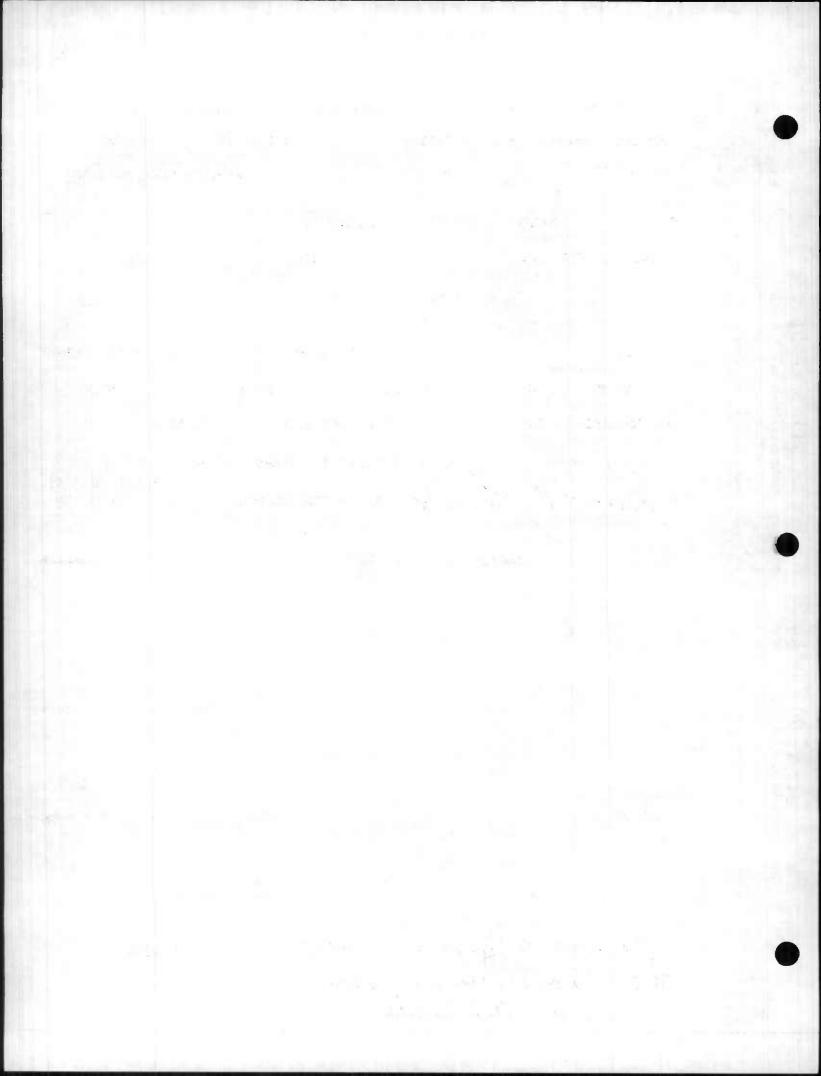
30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

560 RIVERSIDE OR SHOTE AZON, Salisbury, NO 21801

29b. Signeture end title of certifier

JAN 201998

32 Registrar's Signature



98-0137-019

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

4b. City, Town, or Location of Death

4c. County of Deeth

JANUARY 10, 1998

111 Penn Street, Baltimore, Maryland 21201

OTIS		State of Maryland / Department of Health and	8 02	643		
BROWN		Certificate of Death	Reg	, No.		
Physician	1. Decedent's Name (First, Middle, Last,		2. Date of Death Month	Dey	Year	3. Time of Death
/Medical		Brown, Sr.	JANUARY	9,	1998	7:20P.M.

4a Facility Name (If not Institution, give street end number)

Examiner

Funeral Director

the Marylend

pernit. Peges 1 and 2 should be filed within 72 hours after deeth with the Manyler Department of Haalth end Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examination 11 to 11 to 11 to 12 t altimore, Maryland 21215-0020

Physician /Medical **Examiner**

physician end the buriel-transit the death certificate be executed Division of Vital Records, P.O. Box 68760, 65 attending p for use as signed by the aid be detached f is certificate hes director, pega 2 Attending Physician: this funeral death. or Attend after deat Director: 24 hours after Funeral Directory Material filled in b Hospital To the Hoep within 24 ho To the Fune completely fi

4472 CENTENIAL ROAD RHODESDALE DORCHESTER If Under 1 Year 6. Sex 1 M 2 □ F If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months Days Hours Yrs. 69 213-24-1449 March 22,1928 Delaware Usual Residence of Decedent 10d. Inside City Limits 10a, Stete 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Directo Maryland Dorchester Rhodesdale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 4472 Centenial Road 21659 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ◯XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th Laborer Farm 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Viola Frances Watts Arthur Gaines 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 4472 Centenial Rd., Rhodesdale, Maryland 21659 Elizabeth Brown (wife) 20b. Place of Disposition (Neme of cemetery, cremetery or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion U.M. Church Cemetery 1/15/98 Sharptown, Maryland 21. Signature of Auneral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home P.O.Box 1687, Easton, maryland 21601 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death - Thurshot Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Tyes 2 No by 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? Completed completion of cause of deeth? 18-Yes 2□ No 1 No 2 No 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 Naturai 5 Pending 1 ☐ Yes 2 ☑ No Sulgert Shot investigation 1-9-98 2 Accident 1808 281. Location (Street and Number of Rurel Route Number, City or Town, State) 4472 Continual Road Rhodesdale, Don Chester Co. MD 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

O.C.M.E.

Registrar

31. Date filed (Month, Day, Year) JAN 1 5 1998

DONALD

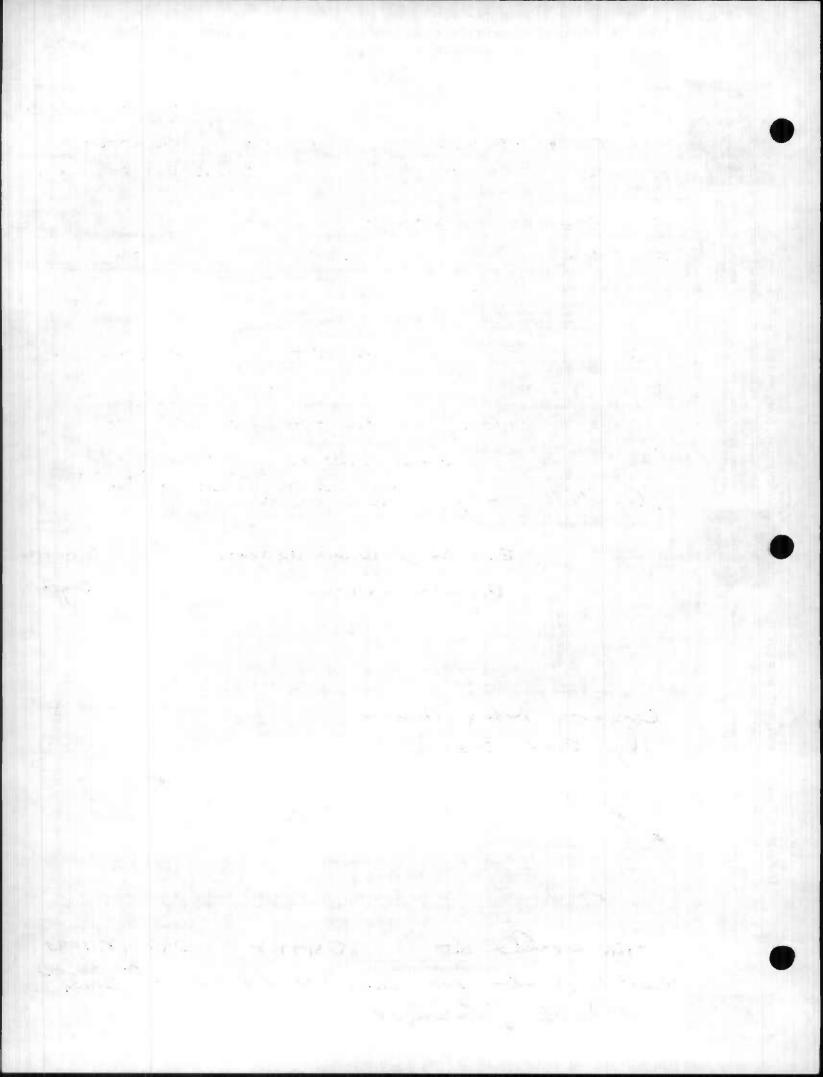
30. Name and address of person who completed cause of death (item 23a) (Type, Print)

G. WRIGHT

32. Registrar's Signeture Julia Davidson-Randell

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 2 6 4 4 State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg	g. No.			
Physician	Wrange II Dence	2. Date of Death Month January	3. Time of Death 5:45 PM			
/Medical Examiner	4a Fecility Name (If not institution, give street and number) 4b. City, Town, or L		16, 1998 4c. County of Death			
Funeral Director	A Land American American		Anne Arund (ear) 9. Birth Con 1920 Nort	del nplece (State or Forei untry) th Dakota		
anyland show	Usual Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limit		
deeth with the Maryland ms 23a or 28a-f show Linist be notified at neral Director	MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	1 ☐ Yes 2 ☒ N		
h with	3406 May Street 20906		USA	, .		
of, or its	If Yas, Give 1 ☐ Yes 2點 No Specify: Year or Dates:	pecify Yes or No- Rican, etc.)	14. Raca - Amer Black, White Specify:			
within sne.	15. Decedent's Education (Specify only highest grade completed) Etamentary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during most of work done		6b. Kind of Business/i			
E SETT	17. Father's Name (First, Middla, Last) 18. Mothar's Nam	na (First, Middle, Ma		y county		
d 2 should be the end Mente 7 is marked traumatic every found to the following the end of the end o	Norvai Alonzo Oakley Donal	da Jane G		Pin Codel		
C = 0 -	Joan Burke (daughter) 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru 1407 Fairbanks Drive,			ip Cooe)		
He He	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spacify) 20b. Placa of Disposition (Name of cametery, crematory or other placa) Parklawn Memorial Park	Date 20	Oc. Location - City or T			
permit. Pages Department of Important: If I any Injury or once.	21. Signature of Foneral Service Licensee 22. Name end Address of Facility Fr	ancis J.		uneral		
Physician /Medical Examiner sthe buriel-transit edical Examiner	Immediate Cause (Final disease or condition rasulting in death) a. End Stepe Men-1 Disease or condition Due to (or as a consequence of): Disease well, tus Due to (or as a consequence of):	eate		6 mont		
E 0100 =		62h Didah		As Aba assumed da		
ss thet the death cert gned by the ettendin be detached for use by Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Commany British Cities to		acco use contribute	obably Unk		
v require been si should	Hyl Bloom Pressure	24a. Was an performe	ed?	Were autopsy findin available prior to completion of cause of death?		
ictan: The lav certificete has rector, page 2		1 ☐ Yes	4	1 ☐ Yes 2 ☐ No		
2 00		ome 5 Residen	nce 6 Other (Spec	cify)		
After Fune		28d. Dascribe how injury occurred				
To the Hospital or Attending Powithin 24 hours after death. To the Funeral Director: After completely filled in by the funera Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		 Location (Street and Number or Rural Route Number, City or Town, State) 			
24 hour 24 hour Funer etely fill dical	29a. Cartifliar (Check only one) Certifying Physician: To tha best of my knowledga, death occurred at the time, date and placa (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and placa (Check only one)					
within To the comple	29b. Signature and title of cartifier 29c. License number		d. Date signed (Month	n, Day, Year)		
12	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ribert A MILICA MO ZOO3 Freduct 31. Date filed (Month, Day, Year) 32gRegistrar's Signature		JAN 18	1998		
•	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ribert A MILLO MO 2003 Medical	Puwey	Mug	1451 MO		
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature					

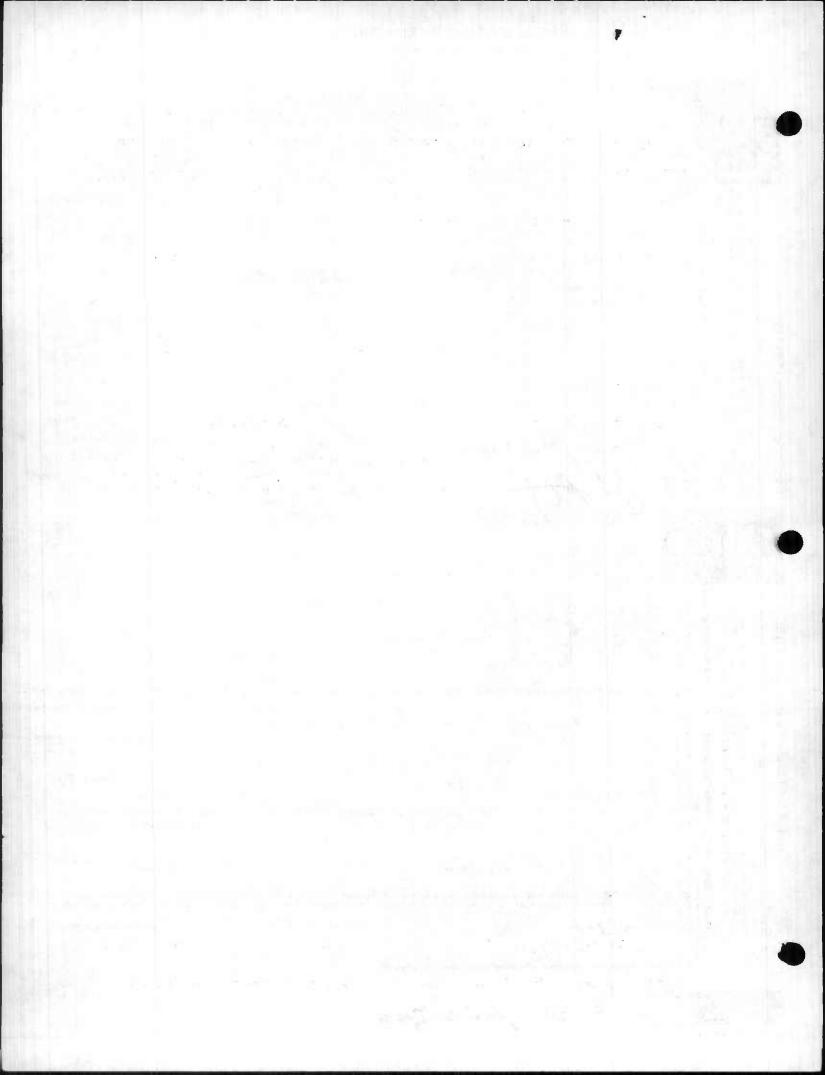


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month Helen N. Barretto January 17, 1998 6:10 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Shady Grove Adventist Nursing Center Rockville Montgomery 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthdey) **Funeral** 8. Data of Birth (Month, Dev. Yeer) Birthplaca (State or Foreign Country) 1□ M 21 F Deys Yrs. Director 577-62-1840 84 Oct. 26, 1913 Philippines Usuel Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location al', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 □ Yes 2 No Directo Maryland Montgomery Potomac 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11613 Bedfordshire Avenue 20854 Funeral United States death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 230 No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2X No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced natural', The Medical Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) United States Baltimore, Maryland 27 Secretary 4 Government 7 is marked other traumatic event, 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental Edward Normandy Isabel Halili 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rene J. Barretto/Son 11613 Bedfordshire Avenue, Potomac, Maryland 20854 permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Jan. 19, 1998 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 M Crametion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Fureral Sarvice Licensea 22. Name end Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, M01126 Rockville, Maryland 20850-2805 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and failure. List only one couse on each line. 23a, Parv. E Annroximete intervel Between Physiclan Onset end Deeth /Medical Immadiate Ceuse (Finel Emphysema disease or condition resulting in deeth) Examiner Due to (or as a consequance of): Osteoporosis The law requires that the death certificate be executed Sequentially list conditions, if eny, laeding to immediata ceusa. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest pue Due to (or as a consequance of): the buriel-trail Box 68760, physician Physician/Medicai Due to (or as a consequence of) signed by the attending d be detached for use es P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Division of Vital Records, by Completed 24a. Wes en eutopsy performad? Were eutopsy findings evelleble prior to complation of ceuse of deeth? certificate has 1 🗆 Yes 1 ☐ Yes 2 No 2 5 No or Attending Physician: Be 25. Was cese raferred to medicel 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Deeth Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Maturel 1 ☐ Yes 2 ☐ No death 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it edicai 29e. Certifia: 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es steted. Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, daeth occurred et tha time, data end place, and due to the ceuse(s) and menner stated. 29b. Signeture end title of pe 29c. Licansa number 29d. Dete signed (Month, Dey, Year) D35792 January 19, 1998 30. Nema and eddress of person who comse of deeth (Item 23e) (Type, Print) Swaroop 6.

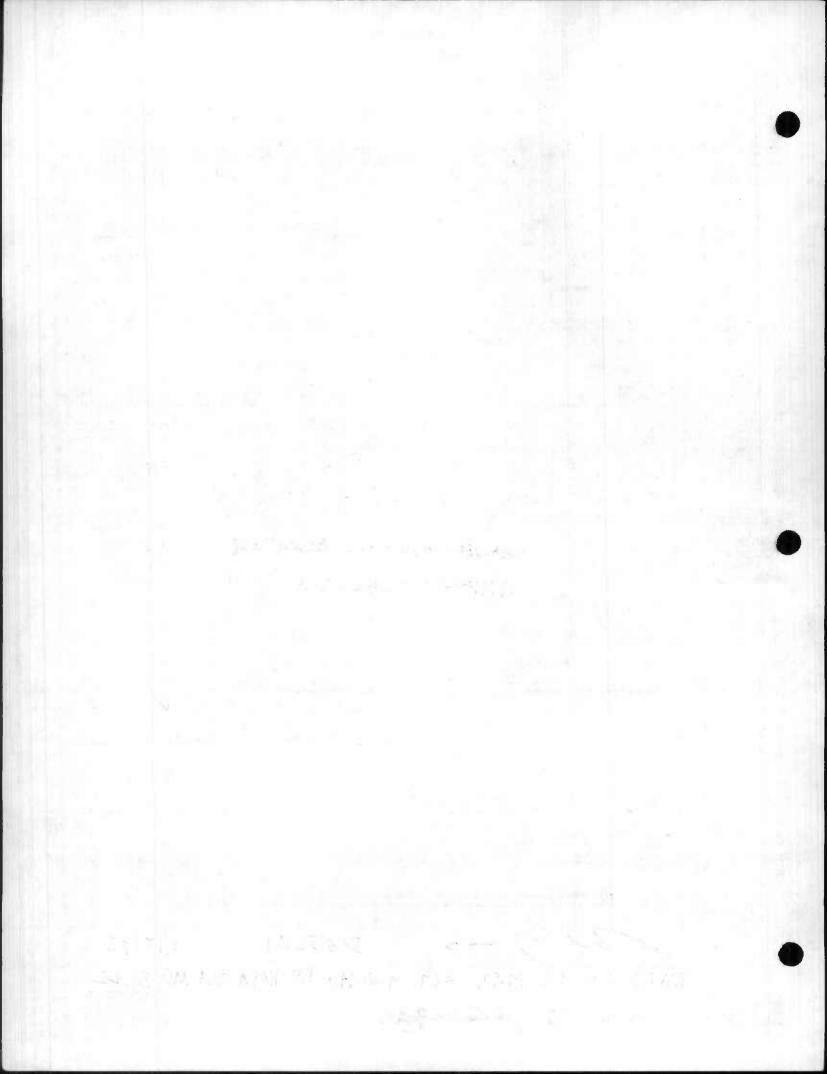
31. Date filed (Month, Day, Year)

JAN 20 1998 Swaroop G. Rao, M.D. 50 West Edmonston Drive #504, Rockville, Maryland 32. Registrer's Signature State his Davidson Registrar



State of Maryland / Department of Health and Mental Hygiene 8 0 2 6 4 6

OFFICE					2. Date of Do Month Januar	Dey	Yeer	3. Time o	of Deeth	
7. Age (ir							Yeer		00011	
7. Age (ir						y 19, 1	998	6:30) DM	
OFFICE				4b. City, Town,	or Location of Dee	1	ty of Deeth	0.50	JEFL	
OFFICE				Rockvi1	le		tgome	ry		
2657	yrs. lest birthday)	If Under Months	1 Year Deys	If Under 24 H		rth		olece (Stete	or Fore	
186-20-3203 95 Yrs. Aug Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					August	gust 21,1902 Pennsylvania				
10	c. City, Town or Lo	ocation						10d. Inside (Dity Lim	
	Rockvill	e						1 ☐ Yes	21	
		10f. Zip	Code			10g. Citizen o	f Whet Cour	ntry?		
			853			United	Stat	es		
Vas Decedent Ever Armed Forces?	in U,S. 13.	Was Deced	dent of I-	lispanic Origin? en, Mexican, Pu	(Specify Yes or Ne erto Rican, etc.)	o- 14. R	eck, White,			
Yes 2 No Yes, Give Yeer or Dates:		1 ☐ Yes				Spec	ify:	White		
n nplated)	16e. Dece	dent's Usua	Occup	petion	un efein m	16b. Kind of				
npleted) College (1-4or 5+)	life.	DO NOT us	nk done se retire	during most of w d)	rorking					
2	C1	erk				Federa	1 Gov	ernmer	ıt	
				18. Mother's N	leme (First, Middle	, Melden Sum	eme)			
				Jennie	Alice C	hase				
Print)	19b. Maili	ng Address	(Street	e <i>nd N</i> um <i>ber</i> or	Rural Route Numb	er, City or Tow	n, State, Zip	Code)		
ter	4802	List	ra R	load. Ro	ckville,	Marv1a	nd 2	0853		
2	Ob. Plece of Dispo	osition (Nen	ne of	on)	Date	20c. Location	- City or To	wn, Stete		
vel from State	Montgome	ry Cr	anua	ry 20,	1998	Rothon	do M			
- 1	22	2. Neme en	d Addre	ss of Fecility R	obert A.	Bethes	ev Fu	aryrar neral	Hor	
my.	M00803 R	ockvi.	lle.	Inc.	300 West	Montgo	mery	Avenue	1101	
ns that caused the use on eech line.							1	Approxime Interval Be	te	
Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): ATHER SCUEROSIS Due to (or es e consequenca of): C. Due to (or es e consequenca of): Due to (or es e consequenca of):										
						22h Did tohacco use contribute to the cause of de				
ing to death but no	t resulting in the u	nderlylng c	ause giv	en in Part I.	23b. Did tobacco use contribute to the cause of					
					_ 1 🗆	Yes 2 No	3 Pro	bably 4	Unkn	
					24a. Wes	en autopsy ormed?	ev	ere eutopsy eileble prior mpletion of	to	
- 35 - 6						/		death?	,au30	
					10	Yes 200 No	10	Yes 2	No	
				26. Plece of D	eeth (Check only	one)				
el: 1 🗆 Inpatient	2 ER/Outpatier	nt 3□ DO	A Oth	er: 4 Nursing	Home 5 Resi	denca 8 □O	ther (Specify	ecify)		
e. Dete of Injury (Month, Dey Yee	28b. Time of Injury	2	8c. Injur Wor	y et k?	28d. Describe	how injury occi	rred			
		М	10	Yes 2 No						
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)					28f. Location (City or To	Street end Nun wn, Stete)	ber or Rure	I Route Nun	nber,	
In the basis of exar	knowledge, death	occurred e	t the tin	ne, date end ple pinion, death oc	ca, end due to the curred et the time,	cause(s) end n	nenner es st	ated.	s)	
nd manner stated.										
7						290. Date sign	Month,	Dey, Year)		
/ -	5					1/1	178			
	(Item 23e) (Type,	Print)	7 4 .	180 0	10.0	1.0	4.14		-	
	end manner stated.	end manner stated.	end manner stated.	end manner stated. 29c. Licens D 3	29c. License number D3562	29c. License number D35621	29c. License number D356ZI 1119	29c. License number 29d. Date signed (Month, D356Z) 1/19/98	29c. License number 29d. Date signed (Month, Dey, Year)	
nd nd	the basis of exammanner stated.	the basis of examinetion end/or in manner stated.	ne basis of examinetion end/or investigetion, manner stated. 29c	ne basis of examinetion end/or investigetion, in my or manner stated. 29c. Licens	ne basis of examinetion end/or investigetion, in my opinion, death occurrence stated. 29c. License number D35621	ne basis of examinetion end/or investigetion, in my opinion, death occurred et the time, manner stated. 29c. License number D356Z	ne basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end pleca manner stated. 29c. License number D356Z	ne basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to manner stated. 29c. License number D356Z 111998	29c. License number 29d. Date signed (Month, Dey, Year) 11998.	



State of Maryland / Department of Health and Mental Hygiene

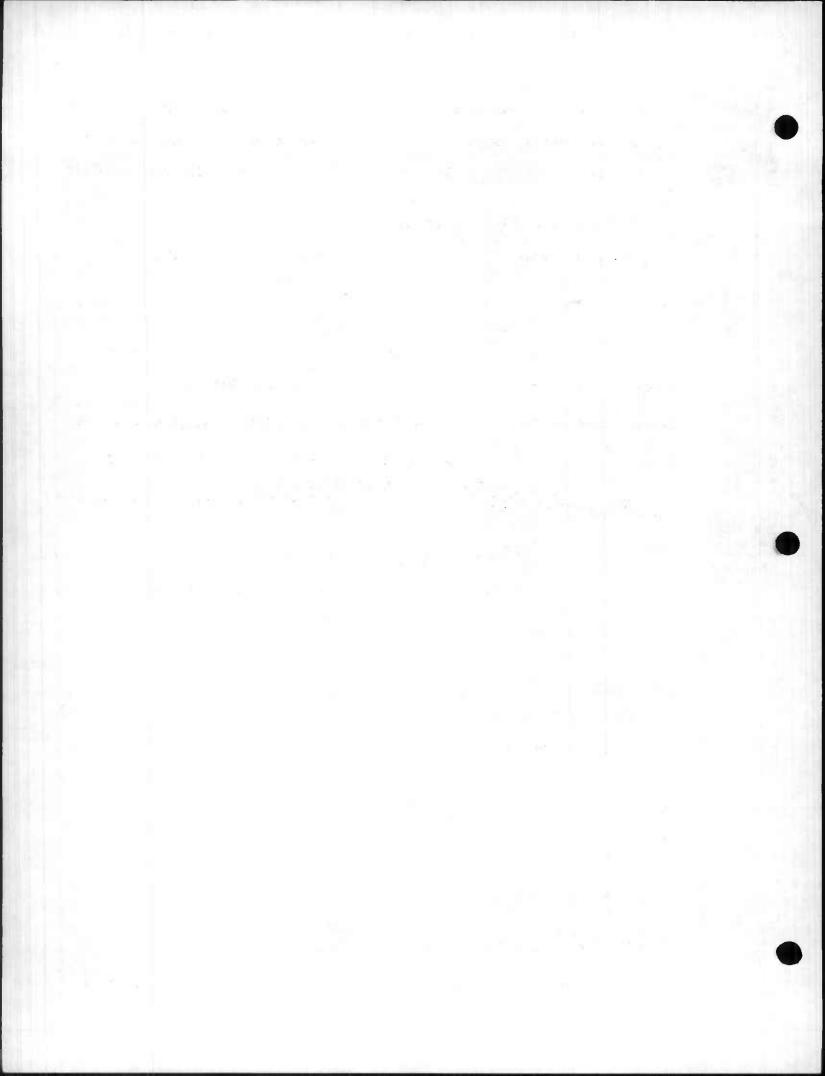
Certificate of Death 1. Decedant's Neme (First, Middle Last) 2. Dete of Death 3. Time of Deeth **Physician** Month Jan. 17,1998 9:45 A.M. Edna Laura Rienvenue /Medical 4e. Fecility Nama (If not institution, giva straet and number) 4b. City, Town, or Location of Deeth 4c. County of Daath **Examiner** Annapolis Anne Arundel Medical Center Anna Arundel 8. Date of Birth (Month, Day, Year) Feb. 18,1922 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 6. Sax 7. Aga (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1□ M 2▼ F Maryland 578-22-0044 Yrs. Director 75 Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28a-f show traumstic event, the Medical Examiner must be notified at 1K) Yes 2 No Director Anne Arundel Arnold 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21012 615 Dunberry Drive Funeral 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify 3₺ Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within: Department of Health and Mentai Hygiene. Important: If Item 27 is marked other than "n any injury or other transmets." Elementery/Secondary (0-12) Coilege (1-4or 5+) homemaker own home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Miller Lucinda Broadwater Henry 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 4716 Davenport St., N.W., Washington, D.C. 20016 Richard Bienvenue/son 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramovel from State 4 ☐ Donetion 5 ☐ Other (Specify) Jan.21,98 Alex., Va. Metropolitan Crematory 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility.
DeVol Funeral Home 2222 Wisconsin Ave., N.W., Washington, DC 20007 Inter the disaase, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, or heart failure. List only one cause on aech lina. Approximeta Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Final CORONANY ARTERY

Due to (or es e consequence of): 3 YEARS disease or condition resulting in death) Examiner Examiner CARDIOVASCUAR DISTHE TRTERIOSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest Due to (or es a consequence of) and physician s the buriel-P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Pert il. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert 1. 23b. Did tobecco use contribute to the cause of deeth? signed by t d be detech 1 ☐ Yes 2 ☐ No 3 □ Probably 4 Unknown HYPERTENSION Records. þ 24a. Was en eutopsy performed? 24b. Were eutopsy findings evailebla prior to Completed OSTEDAN PHRITIS completion of cause of deeth? 2 X No 1 Yes 2 No this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 10 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpetient 3 DOA After this 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred Naturel 5 Pending Invastigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.

2 Medicat Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dey, Year) Do 4899 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 4203 QUEENSBURY ROAD HYATTSUILLE MID J. HAND DENNIS MA 31. Date filed (Month, Day, Year)

JAN 22 1998 32. Registrar's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene R Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month January 14, 1998 Jerome Bodnick 5:15 PM /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Bedford Court Center Silver Spring Montgomery If Under 1 Year if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (Stete or Foreign Country)
 PA 6. Sex X M 2 □ F 7. Age (In yrs. lest birthdey) 578-01-4059 Yrs. 4,1909 88 Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits M☐ Yes 2☐No Funeral Director Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 15210 Elkridge Way #3C 20906 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ∀ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Rep. Liquor Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Benjamin Bodnick Matilda Rodetsky 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Anna Bodnick/Wife 15210 Elkridge Way Silver Spring, MD 20906 20a. Method of Disposition Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Buriai 2 Cremetion 3 DRer 4 Donetion 5 Other Sp city) Judean Mem. Gdns. 1/16/98 Olney, MD. 22. Name end Address of Fecility
Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, 22201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting in deeth) takinson's Due to (or es e consequence of): Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical Be 28. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 ☐ Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end/menner steted. (Check only one) 29b. Signature and pits of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) January 14, 1998 ampleted ceuse of deeth (Item 23e) (Type, Print) f person who RUNIN Amw

State Registrar

Funeral

Director

ntal Hygiene. ed other than "naturel", or fleme 23a or 28a-f show event, the Medical Evantine must be nothing at

Pages 1 and 2 should be filed within 72 hours efter deeth with nant of Haalth and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23s or Jry or other traumatic event, the Medical Evarines in an Lean

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

burial-transit

the

use

has certificate

funerel director.

filled in by

this

After

death.

within 24 hours ofter deal To the Funeral Director:

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Attending Physician:

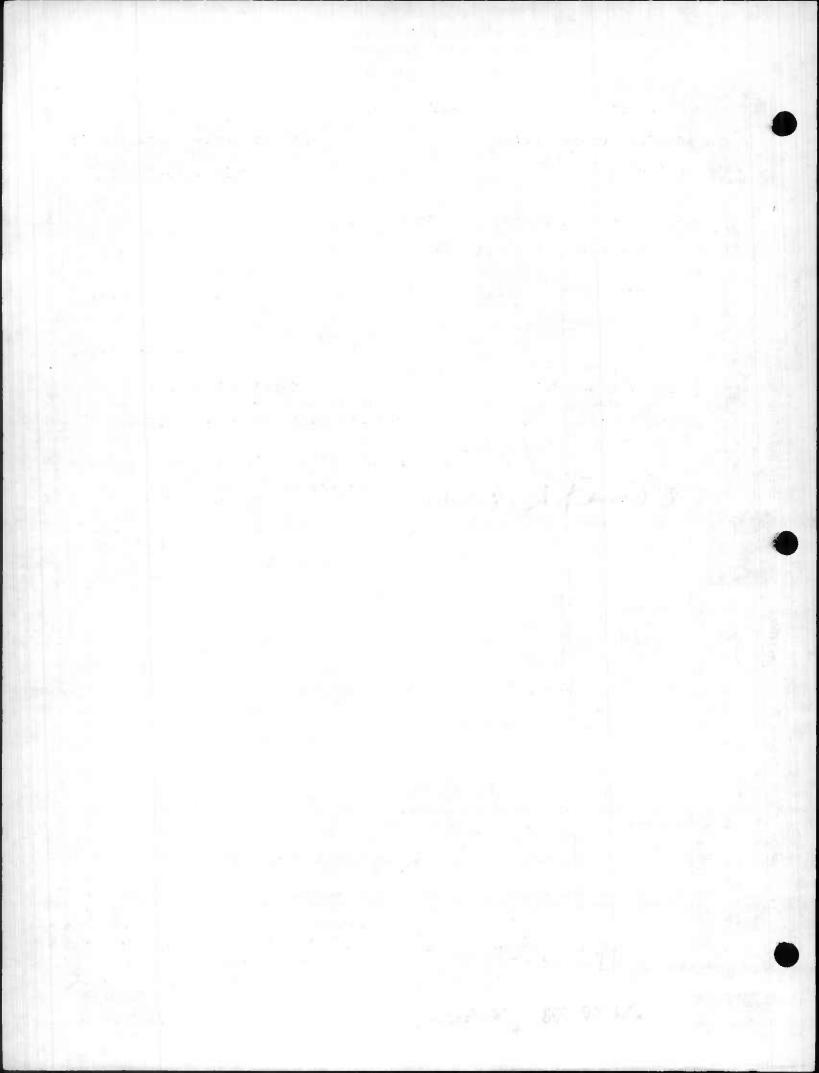
5 Hospital

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Baltimore, Maryland 21215-0020

31. Date filed (Month, Dey, Year) 20

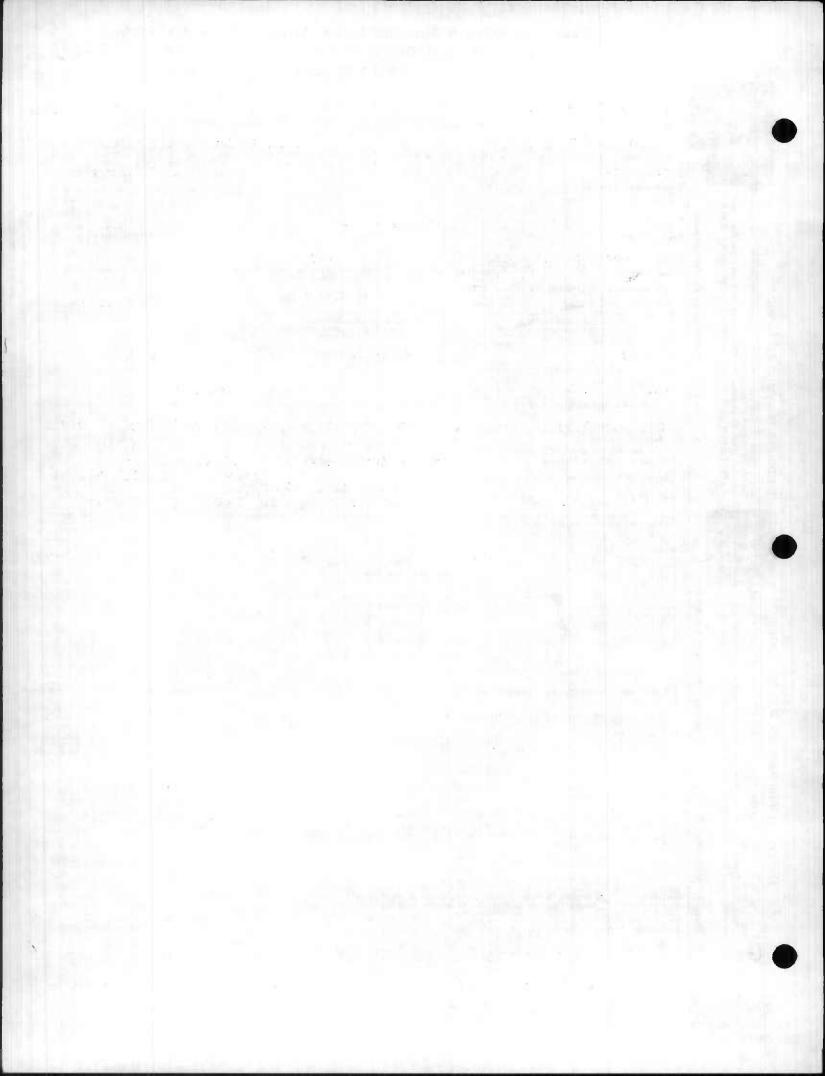
32. Registrar's Signeture Lukia Davidson



State of Maryland / Department of Health and Mental Hygiene 8 0 2 6 4 9

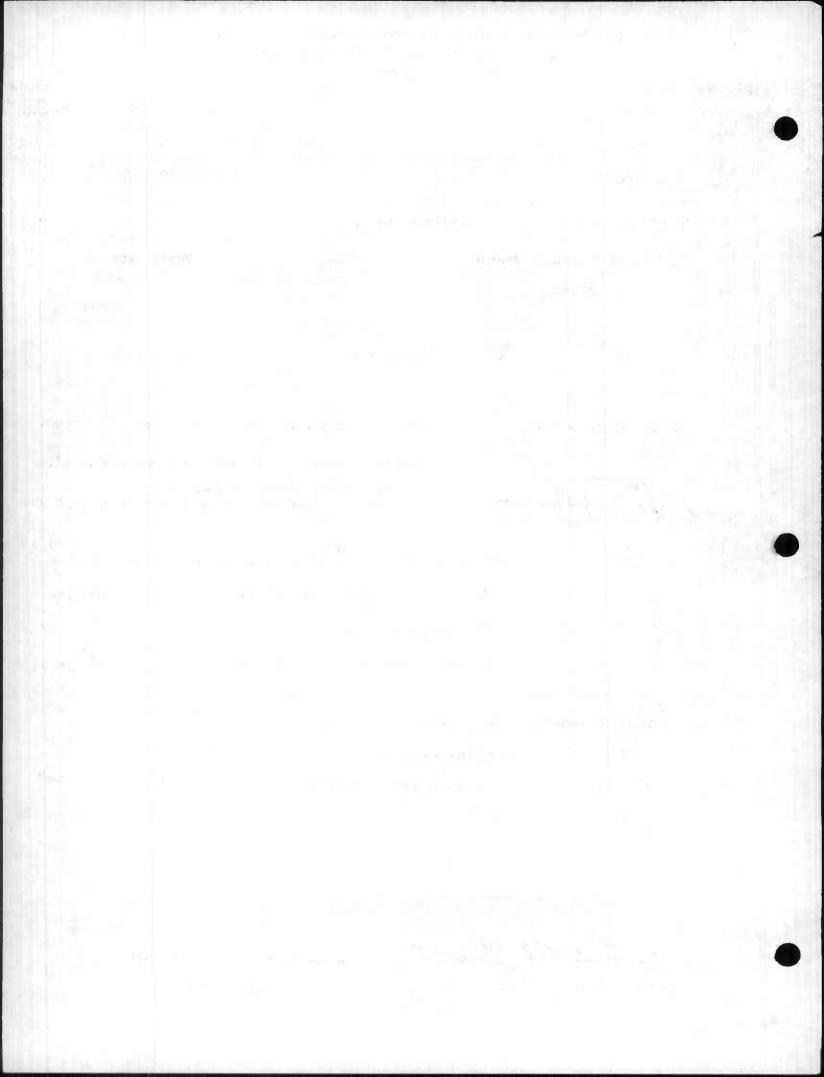
	Certificate o	f Death	Reg	. No.		
	Decedent'a Name (First, Middle, Last)	1	2. Dete of Deeth	Davi	Vana	3. Time of Deeth
Physician	GLADYS C. BUDJAKO		Month JANUARY	20. 1	998	10:35 PM
/Medical Examiner	4e Fecility Neme (If not institution, give street and number)	4b. City, Town, or Lo		4c. County		10.55 111
Examiner	11503 MAPLEVIEW DRIVE	SILVER SP	PRING	MONTO	OMERY	7
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes	ar If Under 24 Hrs.	8. Date of Birth (Month, Dey, Y			ece (State or Foreign
Director	577-46-4537 1□ M 2☑ F 89 Yrs. Montha Dey	ys Hours Min.	Dec. 7,	1908	Mary!	
puel se	10e. Stete 10b. County 10c. City, Town or Location				10	d. Inside City Limits
offer death with the Maryler ritems 23s or 28e-f show the must be notified at Funeral Director	N/A N/A Washington, DC					1 ☐ Yes 2 ☒ No
or 2	10e. Street end Number 10f. Zip Code	•	100	. Citizen of V	Vhet Count	ry?
th w	1718 Newton Street, N.E.	0018		U	ISA	
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and 2 ealth er n 27 ia	Mary Jane Budjako (daughter) 11503 Mapley					
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10588			20901	DIVU.	West	
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hours ineral ly filled	29a. Certifiler 1 Certifying Physician: To the best of my knowledge, death occurred at the (Check only 2 Madical Examiner: On the basis of examination end/or investigation in m	time, date end plece, e	end due to the ceu	use(s) and ma	nner ea st	ated.
To the Hospital within 24 hours within 24 hours Completely filled	(Check only one) 2 ☐ Medical Examiner: On the besis of exeminetion end/or investigation, in mend menner steted.	y opinion, death occurre	ed at the time, det	e and piece,	and due to	the cause(s)
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	30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)	00010			- 0	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GEORGE 5 - KENTON, M-D - 10620 GEORG	HA ANT	SILVER	SPR	INCO	MA 20902
State	31. Date filed (Month, Day, Year) 32. Registrer's Signature			-, -, 1	-7	
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Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Departit Pages 1 and 2 should be filed within 72 hours affer death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Innoctant: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at a property of the contract of the	ANNA BI 4a. Fecility Neme Holy Cr 5. Social Security 195-26-2 Usual Rasidance of 10a. Stata Maryland 10e. Straat and No. 12017 Ne. 11. Maritel Status 1 Navar Mar 3 Widowed (Spe. Elementery/Sec. 12 17. Fethar's Nama Sergei F. 19a. Informant's N. Petro Bi 20a. Mathod of Dia 1 Burial 2 4 Donation	And the state of the second of	Ltal Sax Lre Aven 12. Was Decer Armad For 1 [Yas , Give Yaer or Da ducetion College (1- 4 Typa, Print) 1. Sband Chamber of Sand	7. Aga (In yrs 7 10c. C Si ue dant Evar in trass? 20XNo ates: -4or 5+)	3 Yrs. ity, Town or liver S J,S. 13 16a. Dec (Giv life) Bookl	Months Day Cocation Spring 10f. Zip Coda 20904 Was Decedant of Usual Occa a kind of work don DO NOT usa ratin Keeper Ing Address (Streen	is Hours Min. If Hispanic Origin? (Suban, Maxicen, Puarlo o Specify: upation a during most of wored) 18. Mother's Nat Zinoida et and Numbar or References	Dring 8. Data of Birth (Month, Dey July 28 10 10 10 10 10 10 10 10 10 1	4c. County of D Montgom , 1924 Uk Og. Citizen of Whet United St 14. Race - A Black, W Specify: 16b. Kind of Busine Accountin Maidan Sumama) nable r, City or Town, State	B 8:30 A.M. Death mery Birthplaca (State or Foraign Country) craine 10d. Insida City Limits 1 Yas 2 No t Country? cates Amaricen Indian, White ass/Industry ass/Industry ass.
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2 2 2 2	Pas	tobstru	ntwe	me	s men	ries		24a. Was a perfor	n autopsy med?	4b. Were autopsy findings eveileble prior to complation of cause of death?
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this certific ral director, TO Be		Mo	Hospital:	Datiant 2	ER/Outpati	ant 3 DOA	Xthar: 4□ Nursing h	lome 5 ☐ Raside	ance 6 Other (5	Specify)
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within 24 hours af To the Funeral Di completely filled in	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	yaiclan: To tha b ninar: On tha bas and mann	sis of axamina	owledge, dee ation and/or i	th occurred at tha nvastigation, in my	time, dete end plece opinion, death occu	e, end dua to the c irred at tha tima, d	euse(s) and manne lata and place, and	or as steted. dua to tha ceusa(s)
within 2 comple	29b. Signatura and	titla of pertifier		1		29c. Lica	nsa number	2	9d. Date signed (M	fonth, Day, Year)
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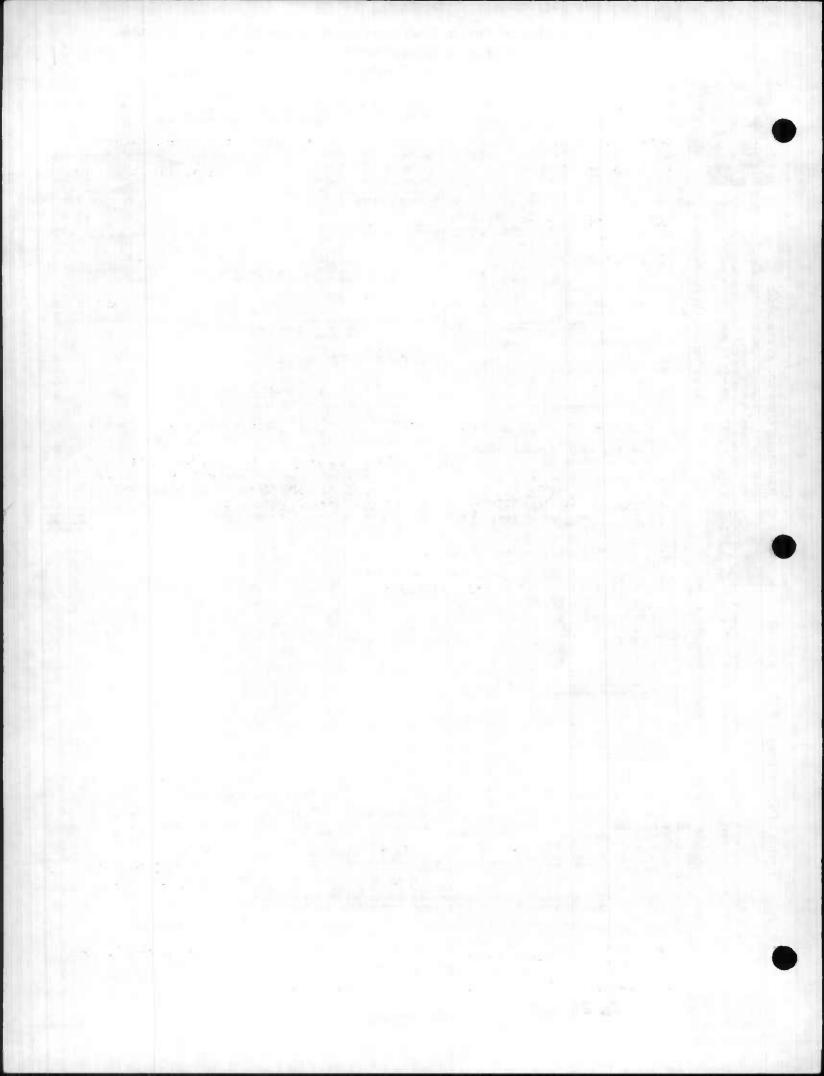


State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:50 PM January 11, 1998 Harry R. Burns /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number If Under 1 Year 6 Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 153 M 2□ F Months Days Yrs. April 4, 184-09-9675 83 1914 Washington, DC Director Usual Residence of Decedent with the Maryland permit. Pagas 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiona. Important: If Item 27 is merked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location. 10d Inside City I Imits 1 ☐ Yes 21 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2201 Colston Drive USA 20910 Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Postal CLerk Postal. 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be R. Harry Burns Annie Fox 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rodney Burns (son) 14100 Poplar Hill Road, Waldorf, MD 20601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 1/15/98 Washington, DC 22. Name and Address of Facility Francis J. Collins Funeral 21. Signature of Funeral Service Licensee 500 University Blvd. West Home, Inc. ante Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Pneumonia days Examiner Due to (or as a consequence of): Examiner Hip Fracture days physician and the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 certificate be Physician/Medical Due to (or as e consequence of): 80 USB Pop ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ Division of Vital Records, 2 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? page 2 s SBC 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1₺ Inpatient 2□ ER/Outpatient 3□ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1⊠ Yes 2□ No Sins funaral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? Certification: 5 Pending 1 Netural 1 ☐ Yes 2X No 24 hours efter death. investigation Dec. 26, 97 1:30 A 2 Accident Fell 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 2201 Colston Dr. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Silver Spring, MD Home Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completaly fi Medicai (Check only one) 2 TMedical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 201 MO D08546 January 13, 1998 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) John Tauber 8218 Wisconsin Avenue, Bethesda, MD 20814

32. Registrar's Signature

his Davidson

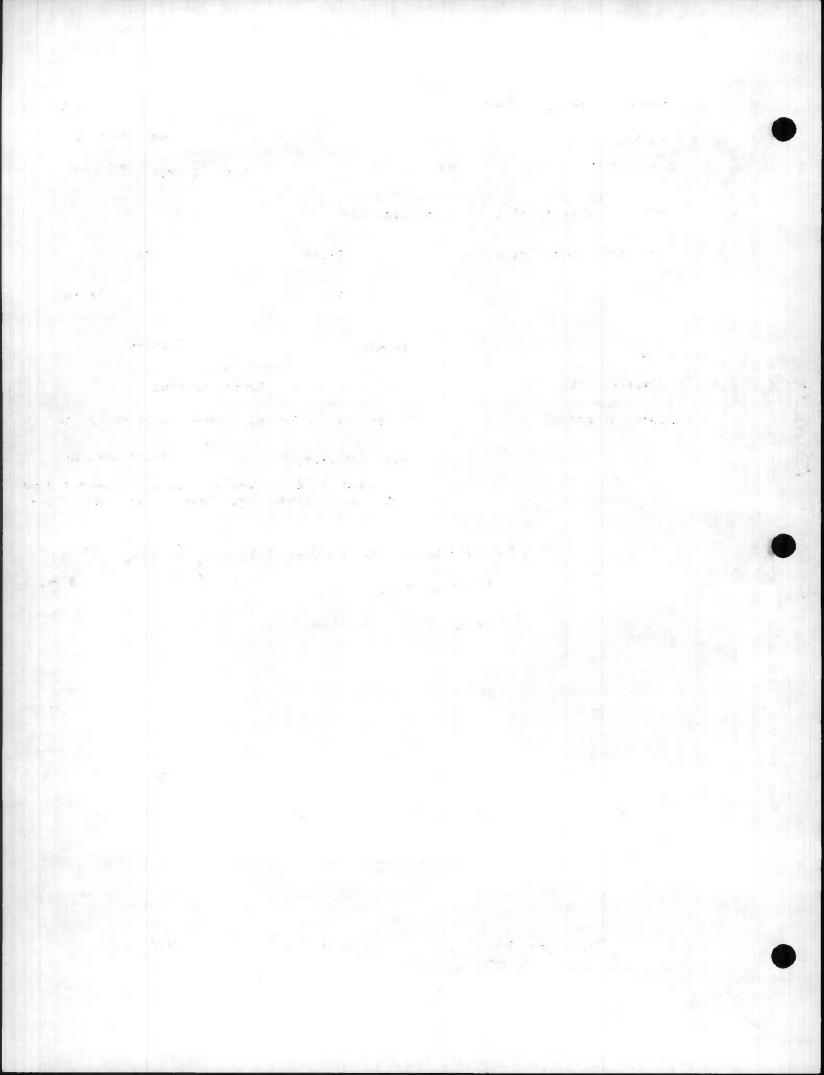
State Registrar



State of Maryland / Department of Health and Mental Hygiene 8 0 2 6 5 2

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hlalaa	_	. Decedent's Name (First, Middle, L	.ast)							2. Dete of De Month	eath Dey	,	Yeer		e of Death
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Il Director	10	0e. Street and Number 317 Marlinspik	e Drive			10f. Zip	Code 211	46				hat Count	ry?		
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ted		15. Decedent's (Specify only highest g	Education	1	6a. Deced	lent's Usu	al Occup	oation	t of workin	a.	16b. Kii	ind of Bus	siness/Ind	ustry	
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Be C	1	7. Father's Name (First, Middle, Las	st)		1111			18. Mothe	er's Name	(First, Middle	, Maiden	Sumame	9)		
To B		Elmer G. Baker							Lau	ra Ho	skin	ıs			
-		9a. informent's Name/Reletionship	(Type, Print)		19b. Mailir	g Address	s (Street	and Number	er or Rurel	Route Numb	er, City o	r Town, S	State, Zip	Code)	
To Be Comp	H	Robert Baker/so	n		317 M	arli:	nspi	ke Dr	ive,	Severr	na Pa	rk,	MD	2114	6
	20	0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Qther (Spec		20b. Plac cem	e of Dispo etery, cren Metr	sition (Nematory or o	other pla			Jan 16 1998 20c. Location - City or Town, Baltimore,					
sician end sician end	2	21. Signature of Emeral Service Lid		-	22	. Name er	nd Addre	ss of Facilit	v						
	1	Part Enter the disease, or of	mplications that caused by one cause on each lin	I the death.	-49	95 Go	v. R	itchi	e Hwy	A. Sever, Sever respiratory e	verna		rk, M	D Approxi	2114
	d	mmediate Cause (Final disease or condition esulting in death)	. Severe	Due to (or a	Lowe s a conseq	elonguence of):	ستعاه	ctive	Pula	nenosy	dis	seas	e	Man	140
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			d												
Physic	P	art II. Other significant conditions	ns contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to th				se of des	
Be Completed by Physician										24a. Was	s an autop ormed?	psy	ava	ilable pr	esy finding ior to of cause
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ToB		examiner? 1 ☐ Yes ② No	Hospitai:	ent 2 ER	VOutpatier	it 3 🗆 D	OA Oth			ne 5 Res		6 □Othe	er (Specify)	
ation: 1	2	7. Manner of Death 1. SNaturei 5 Pending 2 Accident investigat	28a. Date of inju (Month, Date)	ry y Year) 28	3b. Time of injury	M	28c. Inju Wo 1 □	ryet rk?]Yes 2 □		8d. Describe	how injur	ry occurre	ed		
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to the Fundral Director: After this certificate in complately filled in by the funeral director, page Medical Certification: To Be Com	2	(Check only 2 Medical Expone)	Is ann	ated.		29	D 4	se number	9,		29d. Dal	te signed	(Month, 1	Day, Yea	ir)

EVERETT Baker,



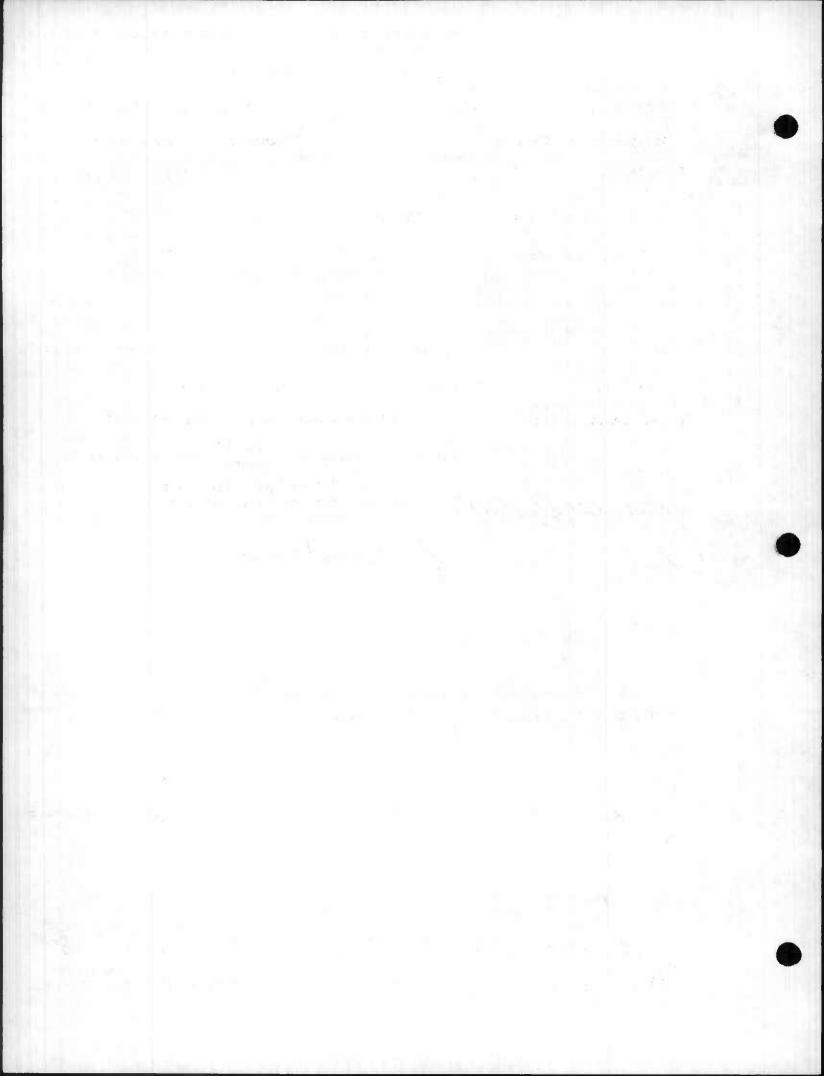
State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Courth Month **Physician** Marina 6:25 mm Bracci January 14, 1998 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice of the Chesapeake Linthicum Anne Arundel 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Days 1□M 21 F 579-28-2709 Yrs. 71 Director Oct 26, 1926 Italy Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at Anne Arundel Linthicum 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 6 817 Camp Meade Road 21090 Items 23a USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 to Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within 7 el Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Insurance Company Administrator permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Nem 27 is marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Analcleto Prosperi Teresa Meloni 19a: Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9005J North Laurel Road, Laurel, MD 20723 Teresa Bracci/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan 17 20c. Location - City or Town, State 1 ⊠ Burlal 2 □ Cremation 3 □ Removal from State Davidsonville, MD Lakemont Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1998 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Signature of Funeral Service License 495 Gov. Ritchie Hwy., Severna Park, MD a modeath. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Physician /Medical Me Cause (Final Due to (a as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in death) Last Due to (or as a consequence of): physician at Box 68760. Due to (or es e consequence of): ettending p Se Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? Records, P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown di sease ò 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed peen 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) HOSPICE 10 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Deeth 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Netural 2 Accident the Hospital or Attending 5 Pending n 24 hours efter deeth.
he Funeral Director: Afte pletely filled in by the fun 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie pletely (Check only one) To the I 29d. Date signed (Month, Day, Year) 29c. License number ne and address of person who completed cause of death (Item 23a) (Type, Print) Peninsula Farm Rd 2733 ON MI 32 Registrar's Signature State

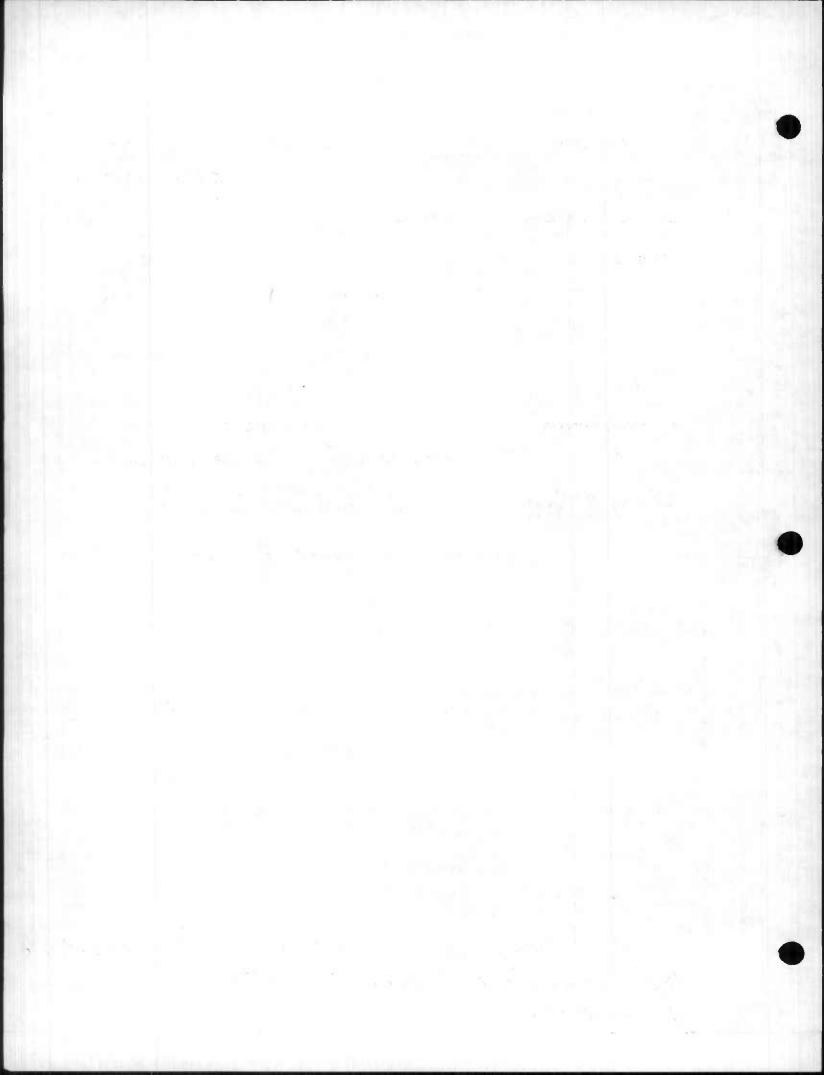
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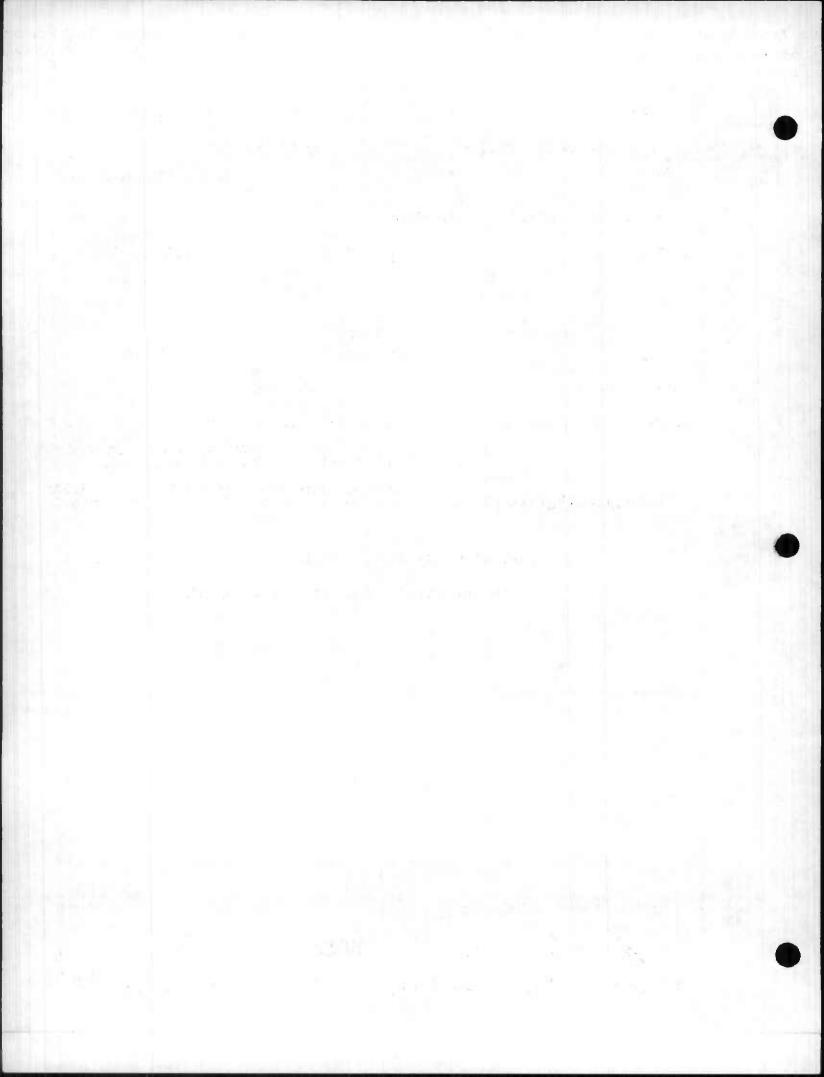
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DORA BROWN A. Facility Name (*find institution, gives afreat and number) 162 0 BERRY COURT ANNAPOLIS ANNE ARUNDEL S. Social Security Number 6. Sex 7. Age (in yrs. last birthosy) If Under 1 Year If Under 2 Hrs. 2. Deed 6 Early, Year Michael 2 Hrs. 2. Deed 6 Early, Michael 2 Hrs. 2. Deed 6 Early, Year Michael 2 Hrs. 2. Deed 6 Early, Michael 2 Hrs. 2. Deed 6 Early, Michael 2 Hrs. 2. Deed 6 Early, Michael 2 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hrs. 2. Deed 6 Hr	State or Ford D side City Lin X¥Yes 2 □
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17. Fether's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame)	
HENRY LANE 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 1	
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MARY BROWN CROWNER (DAUGHTER) 237 ADMIRAL DRIVE ANNAPOLIS, MD. 21401 206. Method of Disposition 1	
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21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 Appropriate School, or hear fellure. List only one cause on each line. 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, therefore one of the contribution of the contri	ato
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30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 1655 (Rofton Blad. Clotton Md. 21114) Beve 3	euse(s)
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State of Maryland / Department of Health and Mental Hygiene 98 02655

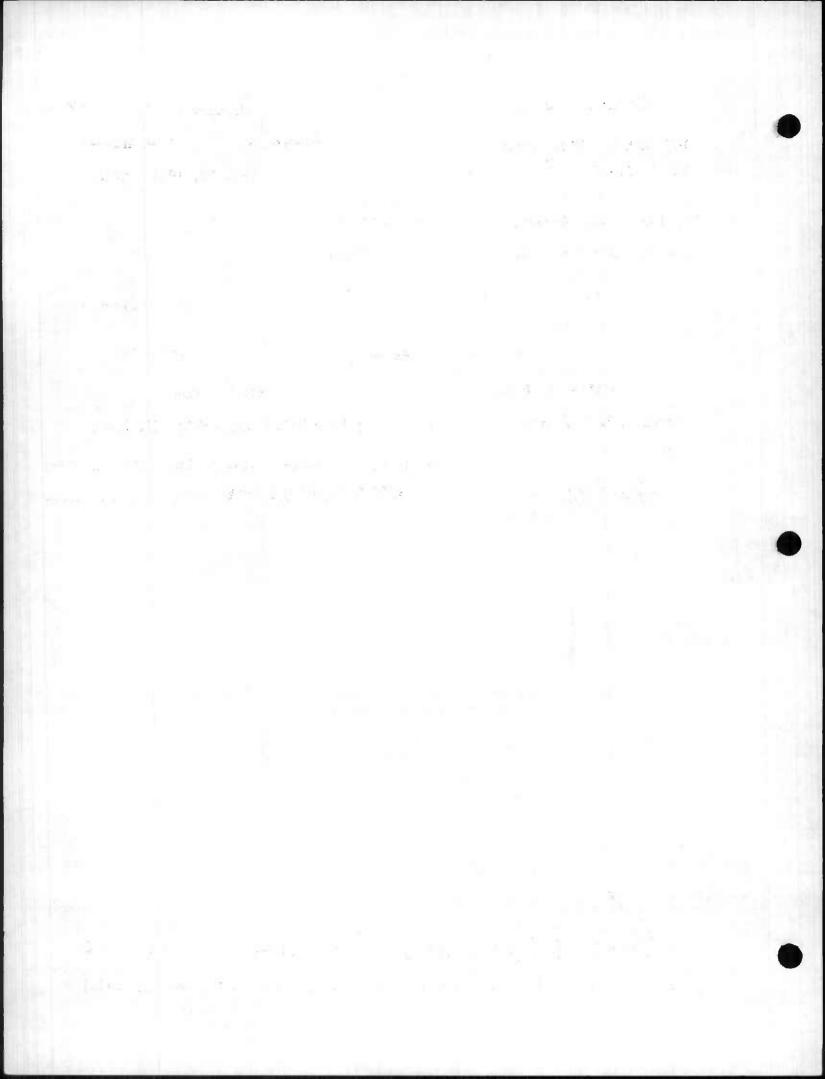
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The latest seems of the la
28e. Date of Injury at Work? 1 Yes 2 No 28d. Describe how Injury occurred
25. Wes case referred to medical examiner? 1
29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Dey, Year)
30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) M. Lemma. ND 1007 Viney and HIL Rd, Caton swille, MD 212
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. Lemma, MD 100 / Vineyard HILL Ka, Catonsville, Molle
State Registrar 31. Dete filed (Month, Day, Year) JAN 2 0 1998 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

02656

					$C\epsilon$	ertifica	te of	Death		- 1	Reg. No.		
		1. Decedent's Nema (First, Middle, I								2. Dete of De		Van	3. Time of Death
Physic /Medi		William Curt	is Banks	3						Month Januar	Day	Yeer 1998	3:00 A.M.
Exami		4a. Facility Name (If not institution, g	ive straat and nu	m <i>ber</i>)			4	4b. City, To	own, or Loc	ation of Daath		unty of Death	
		149 East Bay Vie	w Drive					Anna	polis	3	An	ne Arů	ndel
Funeral		5. Social Security Number 6.	Sex	7. Aga (In yrs	s. last birthday		r 1 Yaar	If Undar	24 Hrs.	8. Date of Birt	th		place (Stete or Foreign
Director	Н	300-42-3146	1₾M 2□F	49	Yrs.	Months	Deys	Hours	Min.	(Month, De Peb. 29), rear)	8 Oh	intry)
2		Usual Residence of Decedent											
72 nours enter death with the Merylend natural, or frems 23e or 28e-f show Most Examiner mark be notified at		10a. Stata 10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Limits
diffe.	cto	Maryland Anne A	rundel		Ann	apoli	S						1 X Yes 2 □ No
or 2	Directo	10e. Street end Number					p Code				10g. Citizer	of What Cou	intry?
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ital Hygiena. do other than "natural", or items 23a or 28a-f show event, the Medical Examinet must be notified at		1 Never Married 27 Married	1 ☐ Yas If Yes, Gir	2 ₹No		1 ☐ Yes		Specify:		. Children	So	anih u	
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If item 27 is marked other is or other traumatic event, it	2		A. Bank	S						ith Ta	3	-	
		19e. informent's Name/Relationship				-				Routa Numbe			
em 27		Cheryl L. Banks/	Wife	l nai				ew Dr	ive	Annapo			
a to		20e. Method of Disposition 1 ☐ Uriai 2 ☐ Cramation 3	□Removel from		Plece of Disp cemetery, cre	emetory or	me or othar plac	ce)		Data	20c. Locat	ion - City or T	own, Steta
lury lury		4 □ □ onetion 5 □ Other (Spec	eify)	An	napoli	s Mem	11. (Garde	ns 1-	20-98	Anna	polis,	Maryland
Department of Health Important: If item 27 is any injury or other tre once.		21. Signature of Euneral Service Lig	ensee		2	2. Name a	nd Addra	ss of Facilit	itv				
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		veter	1/K	oke	(M)		W	105	104		11	141	98
		30. Name and eddress of person who	completed caus	e of seath (Ite	m 23a) (Type	, Print)							-
		Peter R. Graze	, M.D.	900 Be	stgate	Rd.	Suit	e 300	Anna	apolis,	Mary	land 2	1401
Sta	te	31. Date filed (Month, Dey, Year)	32. R	egistrer's Sign		1 00							



State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth **Physician** BARRETT PATRICIA LILLIAN 2:30fm JANUARY /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner GEN BURNIE IT II Under 24 Hrs. 8. Date AA COUNT ARUNDEL NORTH HOSPITAL If Undar 1 Year Birthplece (Steta or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1□ M 2X F Months Days Hours 217-40-5238 54 Yrs. MARYLAND Director MAR. 17, 1943 Usuel Residence of Decedent the Meryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE Directo 10e. Street and Number MILLENNIUM NURSING HOME 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be r 7575 E. HOWARD ROAD 21060 U.S.A. Funeral 14. Race - American Indian. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) Black, Whita, etc. 1f Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Yes 2X No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Hygiena. WAITRESS FOOD SERVICE N/A 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Pages 1 and 2 should be 1 FRANCIS JOSEPH BARRETT LILLIAN MARGARET DEHN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) CATHERINE SWIMM (SISTER) 4427 STURBRIDGE DRIVE, SALISBURY, MD. 21804 27 20b. Plece of Disposition (Name of cematary, crametory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition Burial 2 Crametion 3 Ramoval from State 4 Donation 5 Other (Specify) 1/21/98 BROOKLYN PARK, MD. CEDAR HILL CEMETERY 22. Name end Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, ck, or heer failure. List only one cause on each line. Intervet Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner ACCIDENT physician and the bunal-trensit the deeth certificata be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest P.O. Box 68760. Physician/Medical Dua to (or as a consaquance of): 88 ettending p for usa as signed by the e Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown MELLITUS Division of Vital Records. þ 24b. Were autopsy findings availebla prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed s cartificate hes t 1 Yes 2 No 1 ☐ Yes 2 No Attending Physicien: director, 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1X Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident Investigation ofter deatl 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours efter the Funeral Direction of Files of the Control of th 4 Homicide ō Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted. edical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. To the I within 2 To the I complet 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number eme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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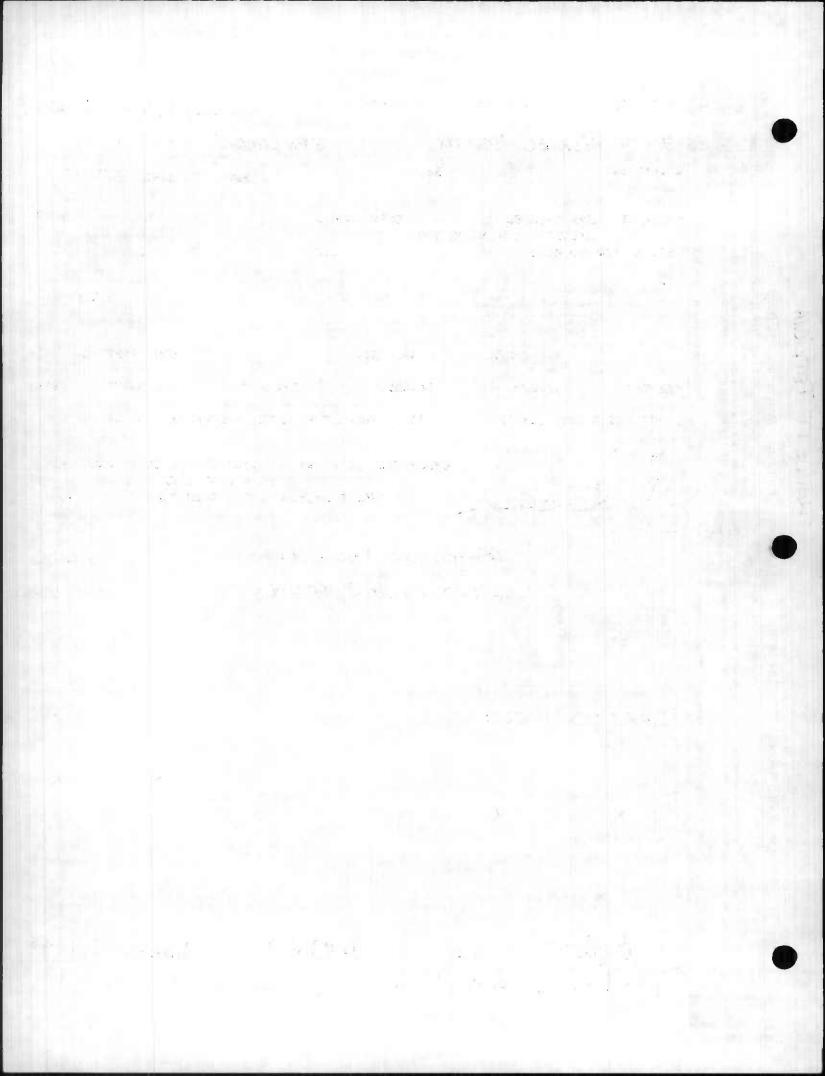
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31. Date filed (Month, Day, Yeer) 1998

State Registrar

RABBETT PATRICIA



State of Maryland / Department of Health and Mental Hygiene \(\)

Certificate of Death

3. Tima of Deeth

Birthplaca (Stata or Foraign Country)

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Virginia

2 years

Approximata Intarval Batwe Onset end Deeth

1 M Yes 2 □ No

Virginia

White

3:25 am

Yaar

1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Charlotte H. Booth January 20 1998 /Medical 4a. Facility Nema (If not institution, give streat and number)
Millennium Nursing and Rehabilitation 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Glen Burnie Anne Arundel 5. Social Sacurity Number If Under 1 Year If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 💢 F 78 Yrs. Director 230-05-7769 4, 1919 Usual Residence of Decedant the Marylend 10a Stata 10b. County 10c. City, Town or Location "natural", or Items 23e or 28a-f show adical Examiner must be notified at Director Maryland None Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3549 S. Hanover Street 21228 United States of Amerida Peges 1 end 2 should be filed within 72 hours after death neart of Health end Mental Hygiene.
Int: If item 27 is marked other than "natural", or Items 23 ury or other traumatic event, in Medical Experient man. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No if Yas, Giva Yaar or Datas; Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Spacify: þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Farell Headley Lizzie Vanlandingham 2 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Numbar, City or Town, State, Zip Code) Mary Ellen Whay - Daughter 3549 S. Hanover Street Baltimore, Maryland 21225 20a. Method of Disposition

2 □ Cremetion 3 □ Ramoval from Stata 20b. Place of Disposition (Nama of cematary, crematory or other place) Date 20c. Location - City or Town, Steta Jan 23 y 1998 permit. Pege Department of Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) Bethany Bapt. Ch. Cemetery Callao, Virginia 21. Signatura 📝 Funaral Sarvice Licensee 22. Nama and Addrass of Facility Jones-Ash Funeral Home P.O. Box 276 Heathsville, Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cerdiac or raspiretory errest, or haart failura. List only ona causa on aach lina. Physician /Medical Immediate Ceusa (Finel Coronary Artery Disease disaasa or condition resulting in daath) Examiner Dua to (or as a consequence of):

Examiner Physician/Medical by Completed Be Medicai Certification: To

bunal-trer

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98 use for

s been signed by the should be detach

page 2 certificate

funeral After efter deeth. filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

Sequentially list conditions, if any, laading to immadiata ceuse. Enter Underlying Ceusa (Disaasa or Injury that initiated evants rasulting in deeth) Last

Essential Hypertension 20 years Dua to (or as a consequence of): Senile Dementia 14 years Dua to (or es e consaquance of): Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

						24a. Was an autopsy performed? 1 ☐ Yes ₩XNo	24b. Ware autopsy findings available prior to complation of cause of daath? 1 \sum Yas 2 \sum No	
25. Was cesa rafarred axaminar?		Hospital:			0	eath (Check only one)		
1 ☐ Yas 2 ☐ No		1 ☐ Inpatient 2 ☐	Homa 5 ☐ Rasidance 6 ☐ Oth	ner (Specify)				
2 Accidant	5 ☐ Pending invastigation	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	286 M	injury at Work? 1 ☐ Yas 2 ☐ No	28d. Dascribe how injury occur		
3 ☐ Sulcide 6 4 ☐ Homlcide	6 Could not ba detarmined	28e. Plece of Injury - At h building, etc. (Special	oma, farm, strae	et, factory,	28f. Location (Straet and Number or Rural Routa Number City or Town, Steta)			

and mennar statad. 20h Sinna

29c. Licanse number D14160

29d. Data signed (Month, Day, Year) 01/20/98

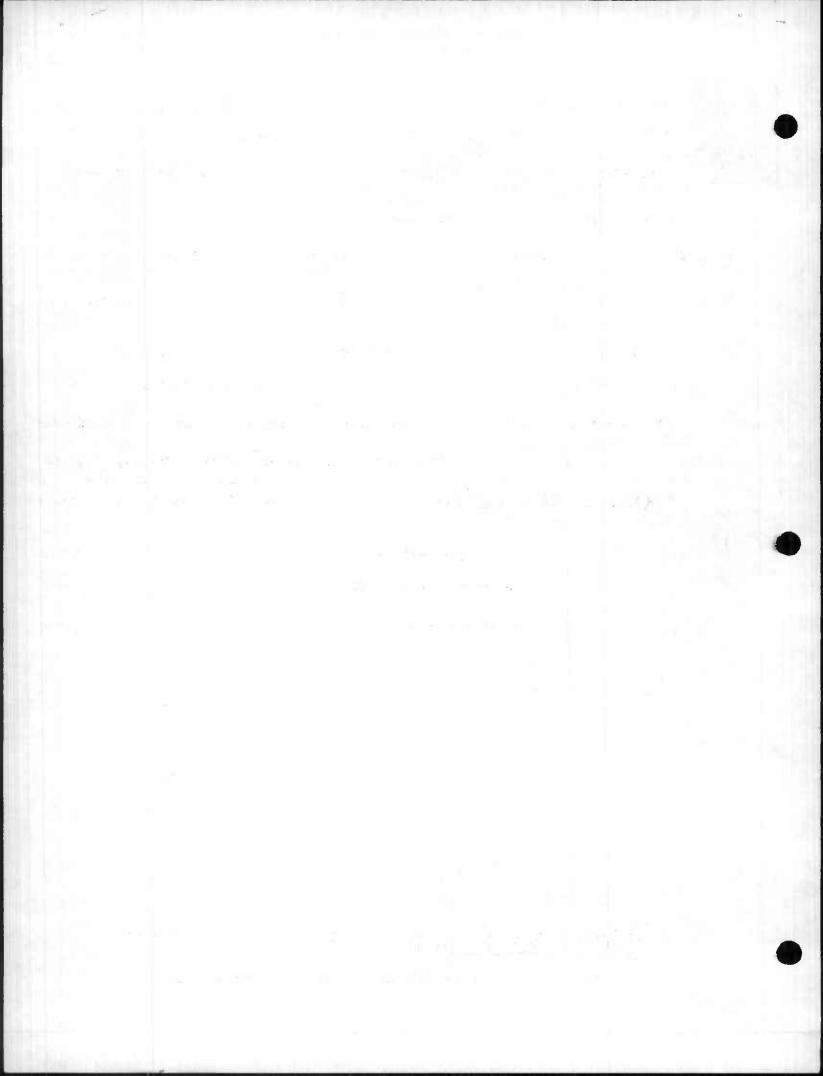
of deeth (Item 23e) (Type, Print) 5410-A Ritchie Highway no complated cause Harjit Singh, M.D. Baltimore, Md .21225

State Registrar

31. Data filed (Month, Day, Yaar) JAN 23 1998 32. Ragistrar's Signatura Davidson-Randoll

within 24 hours e To the Funeral L completely

To the



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Day Merida Elizabeth Brendemihl January 16, 1998 8:20pm 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) Sykesville IrUnder 24 Hrs. 8. Copper Ridge Carroll Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Yeer) Mar 7, 190 7. Age (In yrs. lest birthday) If Under 1 Year 5. Social Security Number 6 Sex Min Months Hours 1□ M 2♥ F Deys 91 Yrs. 1906 Michigan 389-68-2787 Usuel Residence of Deceder 10d. Inside City Limits 10b Counts 10c. City. Town or Location Yes 2 No Carroll Sykesville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 710 Obrecht Road 21784 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☐ ¥lo If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Status Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2√ No Specify: Specify: White 3 Widowed 4 □ Divorced 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) 12 Homemaker Domestic 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Edwin Peterson Emily Frederickson 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Mrs. Diane M. Lawton (Daughter) 10919 Factory Road Glen Arm, MD 21057 20b. Place of Disposition (Neme of cametery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 XBurial 2 ☐ Cremation 3 ☐ Removat from Stete Nashotahouse Seminary 1/21/98 4 ☐ Donetion 5 ☐ Other (Specify) Delafield, WI 22. Name end Address of Facility 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL (Box 195) rum 9 Sykesville, MD 21784 (410)-795-1400 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tntervet Between Onset end Deeth Immediate Ceuse (Final neumenta one month disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown 24a. Wes an eutopsy performed?

Physician /Medical Examiner

important: If its any injury or oth

Physician

/Medical

Examiner

10a State

Director

Funeral

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Completed

Be

MD

Funeral

Director

itel Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examine, must be notified at

the Marylend

death

72 hours efter

filed within

. Pages 1 end 2 should be filt ment of Health and Mentel Hy lant: If Item 27 is marked oth jury or other traumatic event

Examiner physician end s the buriel-trans Physician/Medical ettending ph signed by the e Completed is certificate has director, pege 2: Be this funerai Certification: hours after death.

Division of Vital Records, P.O. Box 68760.

The law requires that the deeth certificate be

Hospital or Attending Physician:

Director: A

24 hours after Funeral Dire letely filled in b

within 2 To the F

þ P

24b. Were autopsy findings aveilable prior to completion of cause of death?

1 Yes 2 W

28d. Describe how Injury occurred

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yeş 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

27. Menner of Deeth 1 Naturel 5 Pending 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homiclde

Investigation 6 ☐ Could not be 28e. Date of Injury (Month, Dey Year) 28b. Time of

MD

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end manner as stated.

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture end title of certifier

29c. License number D25234 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deet (Mem 23a) (Type, Print) ROBERT CAMMLUNK MO

516 N. ROLLING RD SVITE 205

CATONSVILLE

Registrar

edical

31. Date fited (Month, Day, Yeer)

32. Registrer's Signeture

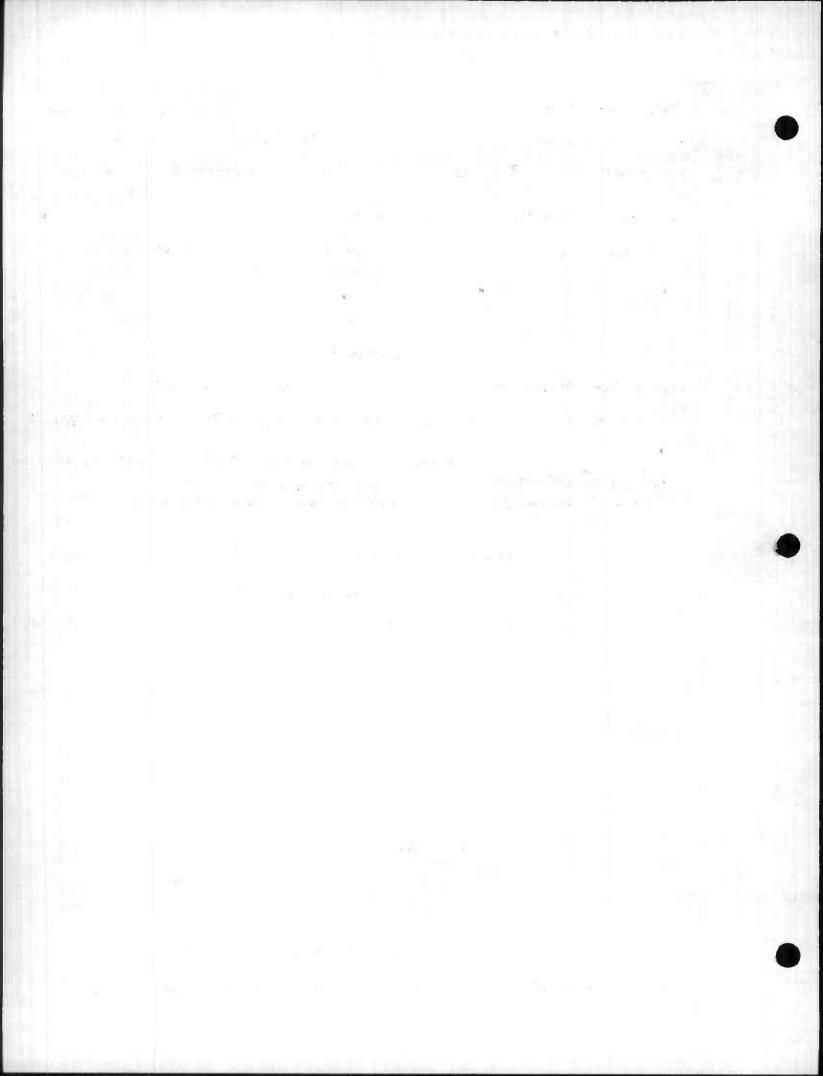
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State of Maryland / Department of Health and Mental Hygiene R Certificate of Death 2. Dete of Deeth Month January 1998 11

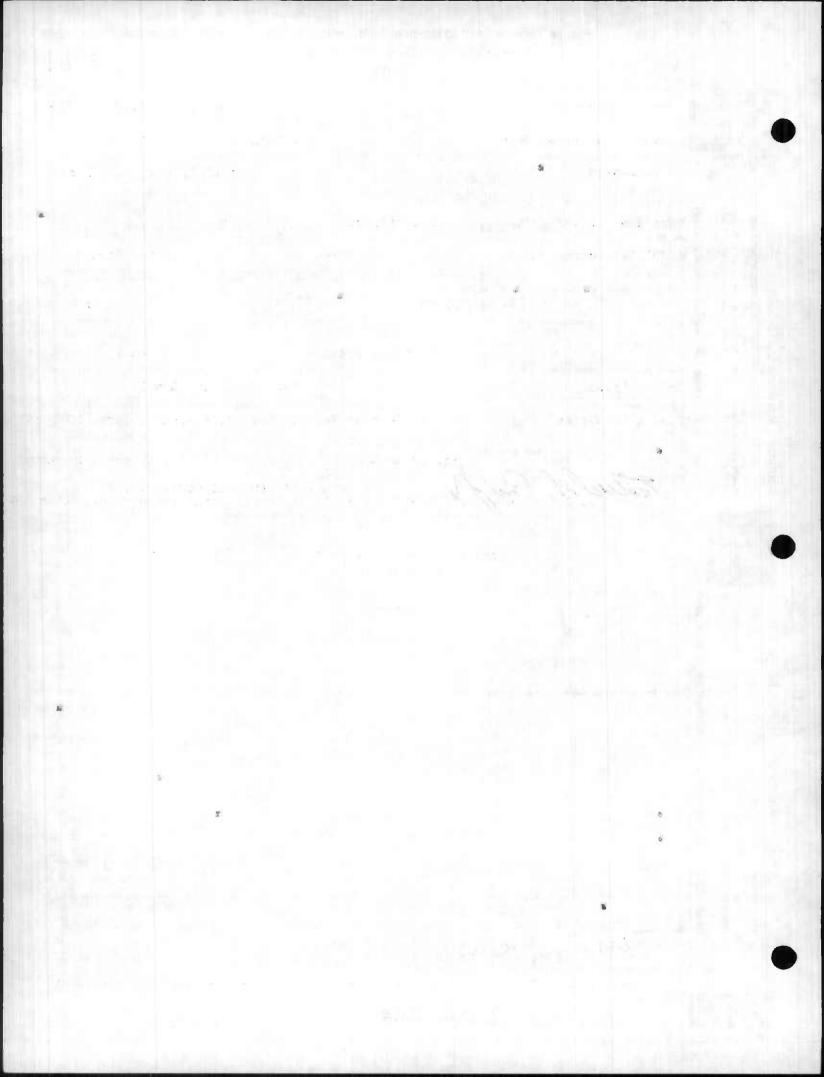
AGNES 1

1. Decedent's Name (First, Middle Last) 3. Time of Death **Physician** Mary Agnes Butler 6:43PM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner St. Mary's St. Mary's Hospital Leonardtown | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | September 18, 1945 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□M 2■F Maryland Yrs. 52 Director 216-56-0095 Usuel Residence of Decedent the Meryland 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-1 show Lexington Park 1 ☐ Yes 2 ■ No Director St. Mary's Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? United States 20653 46388 Peggs Lane Funeral deeth Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2 ■ No If Yes, Give Yeer or Dates: 1 ■ Never Married 2 Married 21215-0020 1 ☐ Yes 2 ■ No Specify: Completed by Black Specify: 3 ☐ Widowed 4 ☐ Divorced traumatic event, the Medical 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry nd Mental Hygiena. marked other than College (1-4or 5+) Elementary/Secondary (0-12) N/A Homemaker Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) . Pages 1 end 2 should be file ment of Health and Mental Hy lant: If Itam 27 Is marked oth lury or other traumatic evem Be William Henry Butler, Sr. Mary Madeline Jordan 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 18 M Lord Calvert Trailer Park, Lexington Park 30653 MD Son George J. Butler, 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or Charles Memorial Gardens 1/15/98 Leonardtown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Africa (1999) 22. Name end Address of Fecility Brinsfield Funeral Home, P.A. K. Blankenship Michael 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heer feilure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical HEART FAILURE Examiner Due to (or es e consequence of): Examiner CHRONIC RENAL FAILURE YEARS Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): 4 MONTHS Box 68760. PERITUNITIS Physician/Medical the Due to (or as e consequence of) signed by the el P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No certificate Hospital or Attanding Physician: 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 Alnpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠ No Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et N/A 5 Pending investigation 1 Naturel s efter death. 1 Yes 2 No NA 2 Accident NA 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours e To the Funeral D completely filled 12 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated. Medical 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Caher W Funners 10 D47825 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 6 ROBERT TIMMONS M.D. PHILIP J. BEAN MEDICAL CTR. HOLLYWOOD, MD. 20636 32. Pegistrar's Signature State

Registrar



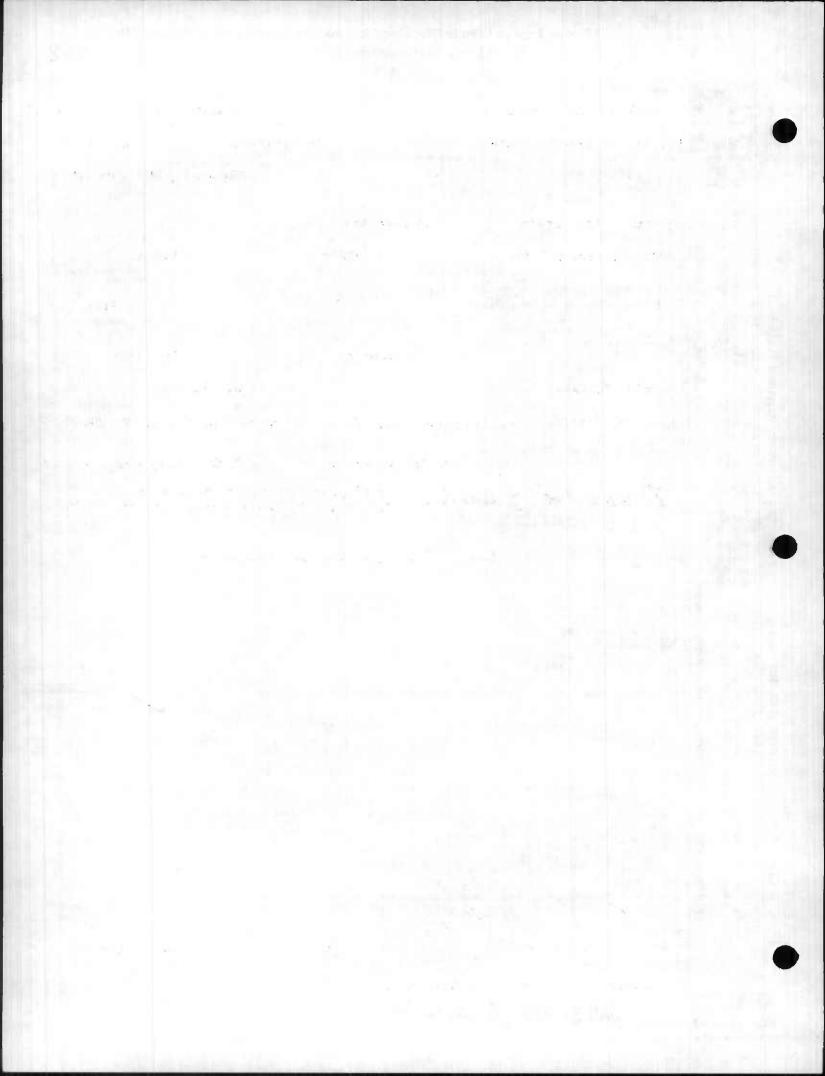
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Physician	Decedent's Name (First, Middle							2. Data of D Month	Day	Yaar 3. Time of		
/Medical	James Flancis		of mount to a al				4b City Town	Januar or Location of Dea				
Examiner	48 Facility Name (If not institution 48907 Chisleyt	St. In:			Mary's							
uneral	5. Social Security Number	6. Sax		rs. last birthda		der 1 Year	If Undar 24 H		irth	9. Birthplace (State or		
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ž	Usual Rasidanca of Dacedant 10a. State 10b. County	,	10c.	City, Town or	Location					10d. Insida Clt		
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or 28a-f e be notified Director	10e. Street and Number	nary 3		00.		Zip Code			10g. Citizen of V	Vhat Country?		
al D		wn Road				2068	4		United	ed States		
"natural", or items 23s or 28s-f show adical Examiner must be notified at ideed by Funeral Director	11. Marital Status	12. Was	Decedent Ever In ed Forcas?	U,S. 1	3. Was Dec	cedent of F	lispanic Origin? an, Mexican, Pu	(Specify Yas or Narto Rican, etc.)	o- 14. Raci Blac	ca - American Indian, ack, White, etc.		
II. or H		If Ye	res 2□No s, Give			2 No	Specify:		Specify	Black		
all all be		nt's Education	or Datas: 1950	16a. De	cedent's U	sual Occur	pation		16b. Kind of Bu	of Business/Industry		
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X -	Roland Barnes								ne Sewell			
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Item 27 other t	20a. Method of Disposition		20	o. Place of Dis	sposition (A	Vame of		Date		City or Town, State		
resident of the second of the	1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		from State	cemetery, o			ca)	1/17/98	St. Ini	igoes, Mary		
	21. Signatura and Berylo	Lightsen /	Sh	. 1000			ss of Facility	1/1///	00. 111	igoes, nary		
	Edward N. H	rinsfie	11/10	M00052					Home, P.A	A. cdtown, MD		
	disaase or condition resulting in death)	a		o (or as a con	sequence o	of):				1		
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	resulting in death) Last	d	Dua to	(or as a cons	sequanca o	f):			air A			
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should should									s an autopsy formad?	24b. Were autopsy fi available prior to complation of co of death?		
ete hes b page 2 s								1	Yes 2■No	1 ☐ Yes 2 ☐		
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ertificate ector, pag Be Col	examiner?		1 Inpatient	ER/Outpa		DUA			sidence 6 Oth			
his certifical director	1 M Yes 2 No	Hospital:	Date of Late	28b. Time		28c. Inju Wo	ryat rk? Yes 2∐No	280. Describe	how injury occur	red		
his certifical director	1 M Yes 2 No	28a. I	Date of Injury (Month, Day Year) Inju			28f. Location (Street and Number or Rural Route Number City or Town, State)					
the funeral director the funeral director cation: To Be	1 M Yes 2 No	28a. I	Date of Injury (Month, Day Year Place of Injury - A building, etc. (Spe	t home, farm,	M			28f. Location City or T	(Street and Numb own, State)	er or Rural Route Num		
Funeral Director: After this certification to the funeral director to the funeral director to the funeral director.	1 M Yes 2 No 27. Manner of Death 1 Natural 5 Pendii 2 Accident invest 3 Suicida 6 Could 4 Homicide	ng gation not be nined 28e.	Place of Injury - A building, etc. (Spe o the best of my	t home, farm,	M street, fact	tory, office	me, date and pla	City or T	own, State) e cause(s) and me			
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	- 30		State of Marylai		tificate of			Reg. No.	0 6	.002	
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Exan	niner	4a Fecility Neme (If not institution, give				4b. City, Town, or	of Deeth				
		St. Mary's Nursin			If Under 1 Year	Leonardt		St. M			
Funera Directo		213-76-5463	ПМ 2ПЕ	88 Yrs.	Months Deys	Hours Min.	(Month, De	y, Year) 7 12, 1909	ece (Stete or Foreign try) land		
pue *		Usuel Residence of Decedent 10e. Stete 10b. County	10c. C	ity, Town or Loc	cation				10	0d. Inside City Limits	
lenyii sho	Į.									1 ☐ Yes 2 🖾 No	
the N	Director	Maryland St. Mar	ys	Leonar	10f. Zip Code			10g. Citizen of W	het Coun	try?	
with with	ā	20838 Waterside	Drive		20650		78. 10.	U.S.A.			
leath 22	era	11. Marital Status	12. Wes Decedent Ever in U	J.S. 13. W			Specify Yes or No		- Americ	an Indien,	
pomit. Peges 1 and 2 should be filed within 72 hours effer death with the Menyland Depertment of Heath and Menilal Hygiene. Depertment if them 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified.	by Funeral	1 Never Married 2 Merried 3 Married 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		Yes, specify Cub ☐ Yes 2 🗓 No	Hispenic Origin? (Sean, Mexican, Puerl Specify:	to Rican, etc.)		Bleck, White, etc. Specify: White		
2 ho	P P	15. Decedent's Ed	lucation	16a. Deced	ent's Usuel Occup	pation	ali la a	16b. Kind of Bu			
Pin 7	Be Completed by	(Specify only highest gre Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT use retire	during most of word)	rking				
d will	PO	8th		Hom	emaker			Own Ho	ome		
al Hygi	e e	17. Fether's Name (First, Middle, Last)				18. Mother's Ner	me (First, Middle	, Meiden Sumeme	8)		
y lail ould be Mental arked o	P	Maurice E. Baker				Netti	e W. Nic	chols			
2 should be end Mental is marked of aumatic sv		19a. Informent's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	t end Number or Ru	urel Route Numb	er, City or Town,	Stete, Zip	Code)	
1 end Health em 27	L-H	Cheryl M. Billite		1		side Dri	ve Leona				
Demit. Peges 1 el Depertment of Heal mportant: If Item any Injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Demoval from State	Plece of Dispos cemetery, crem	sition (Neme of netory or other pla	ice)	Dete	20c. Location -	City or To	wn, Stete	
Pages nent of I	911	4 Donetion 5 Other (Specify		r Lady's	Cemetery		1/27/98	Medley's	Neck,	Maryland	
pemit. Peg Depertment Important: I	ouce	21. Signature of Funeral Service Licen	1509		Neme end Addre			1 11	T) A		
1 2052	a	Michaelx	Mardine	M M	attingle	y-Gardin	er funer	al Home,	, P.A	0650	
Physicla /Medica Examine	al 🔠	23a. Part1. It is the disease, or come shock, a heert feilure. List only Immediate Cause (Finel disease or condition resulting in deeth)	. Demen	lor as e consequ	with		exic			Approximete Intervel Between Onset end Deeth	
D &	ner										
icate be exacuted physician and sthe burial-trensit	edicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	Due to ((or es e consequ	uence of);						
rificate be ex ng physicien es the burial	- D.O.										
deeth certifi e attending jed for use es	Physician/M		d						I		
e dee	SIC	Pert II. Other significant conditions of	ontributing to death but not re	sulting In the un	derlying cause gi	ven in Pert I.	23b, Did	23b. Did tobacco use contribute to the cause of dea			
that the died by the deteched			1	bably 4 Unknow							
requir been s should	been s should					s en eutopsy ormed?	co	ere eutopsy findings elleble prior to mpletion of cause deeth?			
The law ate hes b page 2 s	E						10	Yes 2♥No	10	Yes 2 No	
elclan: T certifical irector, p	0	25. Wes case referred to medical				26. Plece of De	ath (Check only	one)			
Physician: this certific	To B	exeminer? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient	t 3 DOA Ot	her: 4 🖾 Nursing I	Home 5 ☐ Res	idence 8 Othe	er (Specif	y)	
9 Ph er thi		27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	ry et	28d. Describe	how injury occurr	ed		
I or Attending Physelfer deeth. Director: After this din by the funeral d	Certification:	1 [2]Neturel 5 Pending investigation 3 Suicide 4 Homlcide		home, ferm, stre	M 1	Yes 2 □ No		(Street end Number wn, Stete)	er or Rure	I Route Number,	
To the Hosphal or Attanding Physician: The law within 24 hours efter deeth. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edical Cer	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Examone)	ysician: To the best of my kn inner: On the basis of examin and manner mated.	owledge, death	occurred et the ti	ime, date end place	e, end due to the urred et the time	ceuse(s) end me , dete end plece, e	nner es si end due to	tated.	
the the	Mec	29b. Signeture end title of certifier	ally glathiol stated.	>	29c. Licen			29d. Date signed			
F.¥F.8		- I Gordania	111/			19917		1/	198		
		20 Name and state of	X	m 02c) (T		1111		1/26/	70		
		James C. Boyd			MD 206 J	9					
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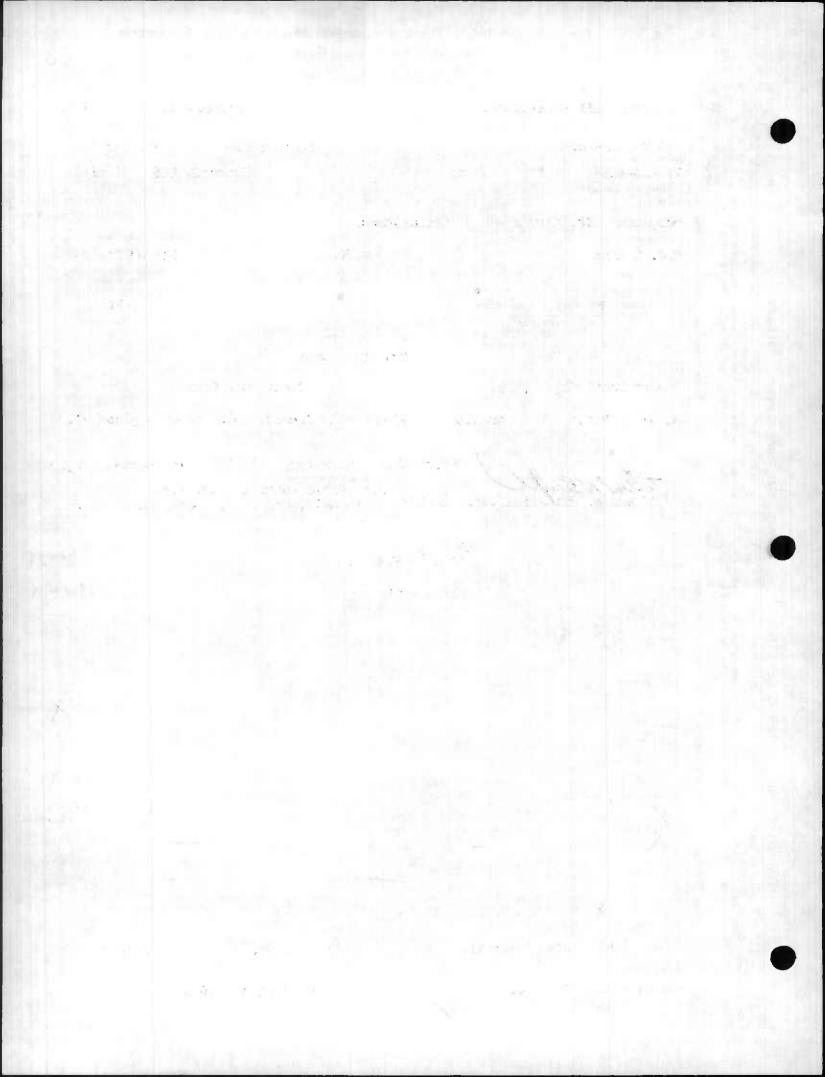
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State of Maryland / Department of Health and Mental Hygiene 9 8 0 2 6 6 3

					Cert	ificate	of Death		Reg	g. No.	0 6	100	0
		Decedent's Name (First, Middla, Las	it)		- 113		4-4-1	2. Date Mon	of Death	Day	Yeer	3. Time	of Death
Physician /Medical		Edward Cecil Boy	kin, Jr.					-	uary	24, 1		1300)
Examiner	40.1	Facility Name (If not institution, give	street and number)				4b. City, Town	, or Location of	Death	4c. County			
	_	25 Park Avenue					Leonar	rdtown		st.	Mary	1 0	
Funeral	5. S	ocial Security Number 6. Se		e (In yrs. la		If Under 1		Hrs. 8. Date	of Birth oth, Day, er 3,	Year)		ace (Stata	or Foraig
Director		19-30-4654	■ M 2□ F	62	Yrs.	NIOTICIS	Days Hours	Octob	er 3,	1935	Virg	ínia	
*	-	al Residence of Decedent . State 10b. County		10c. City.	Town or Loca	ntion					10	d. Inside (City Limit
show a													s 2 N
28a-f show	100	aryland St. Ma: Street and Number	rys	Lec	onardto	WΠ 10f. Zip (Code		10	g. Citizen of \	What Count	m/2	
r tems 23s or 28s-f show ther must be notified at Funeral Director	P	.0. Box 53					0650			Unite			
era era	11	Maritel Status	12 Was Decedent	Ever in I1S	13 W			2 (Specify Yes	or No-		e - America		
1 P		1 Never Married 2 Married	12. Wes Decedent Armed Forces? 1 \(\text{Yes} \) 2		lf Y	es, speci	ent of Hispenic Origin fy Cuban, Mexicen, F	uerto Rican, e	tc.)		ck, White, e		
0 0 >		3 ☐ Widowed 4 ■ Divorced	If Yes, Give Yeer or Detes:		10	Yes 2	■ No Specify:			Specify	Whi	te	
"natural", or its of cal Examine leted by Fur		15. Decedent's Ed	ucation	1	16a. Decede	nt's Usual	Occupation		1	6b. Kind of B			
	-	(Spacify only highast grad		F.,)	(Give ki	nd of work NOT use	k dona during most of a ratired)	f working					
r than	[]	lementary/Secondary (0-12)	College (1-4or	0+)	Shoe	Repa	airman						
d other event, Be Co	17.	Fether's Name (First, Middla, Last)						Name (First, I	Middla, M	aiden Suman	7a)		
Mental Mental artic ev	E	dward Cecil Boyk	in, Sr.				Glady	ys Ola	Coun	ts			
PEE	19a	a. Informant's Name/Relationship (7					(Street and Number						
27 la r trau	Wa	anda L. Braun,	Daugh	ter	1537 M	iarsh	all Street	t, Balt	imore	e, Mar	yland	2123	10
if of Heal If Itam 2 or other	20a	. Method of Disposition		20b. Pla	nce of Disposi matary, crams	tion (Name	a of	Date	2	0c. Location -	City or To	wn, State	
y or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Spacify						1/27/	00 7	lexand	ria '	Ti wari	nia
Department of Health Important: If Itam 27 any Injury or other to ance.	21.	Signature of Funeral Service Com-	AU	reci			rematory Address of Facility	1/2//	90 A.	rexauc	Lidi	virgi	IIId
Departri Importa any Inju		Edward N. Brins		3400			field Fund						
	100				0052 2	2955	Hollywood	d Road,	Leon	nardto	wn, M	d 206	50
	256	a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each li	ne.	DO HOL BILLET	1110 111000	or dying, addition to	noide of respire	atory arro-	J.,		Approximation of the conset and c	etween d Deeth
hysician /Medical	Imr	nediate Cause (Finat			_								
xaminer	dise	ease or condition ulting in death)	a	Dep	as a conseque	= m	IA					- Hc	ins
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el-tre	Sec if a	quentially list conditions, ny, leading to immediate ise. Enter Underlying use (Disease or Injury		Due to (or	as e consequi	ence of):							
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ng physicia es the bu	res	ulting in death) Last		Due to (or e	es e conseque	ence of):							
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ate has been signed to page 2 should be det								245	a. Was en	autonev	24b. We	re autops	v finding
been s should								-	perform		cor	nilable prio	rto
has ye 2										1/	of	death?	V
pege pege									1 ☐ Yes	s 200 No	1 [Yes 2	No
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his certific il director To Be		Manner of Death	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		Bc. Injury at Work?		scribe no	w Injury occur	rea		
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State of Maryland / Department of Health and Mental Hygiene

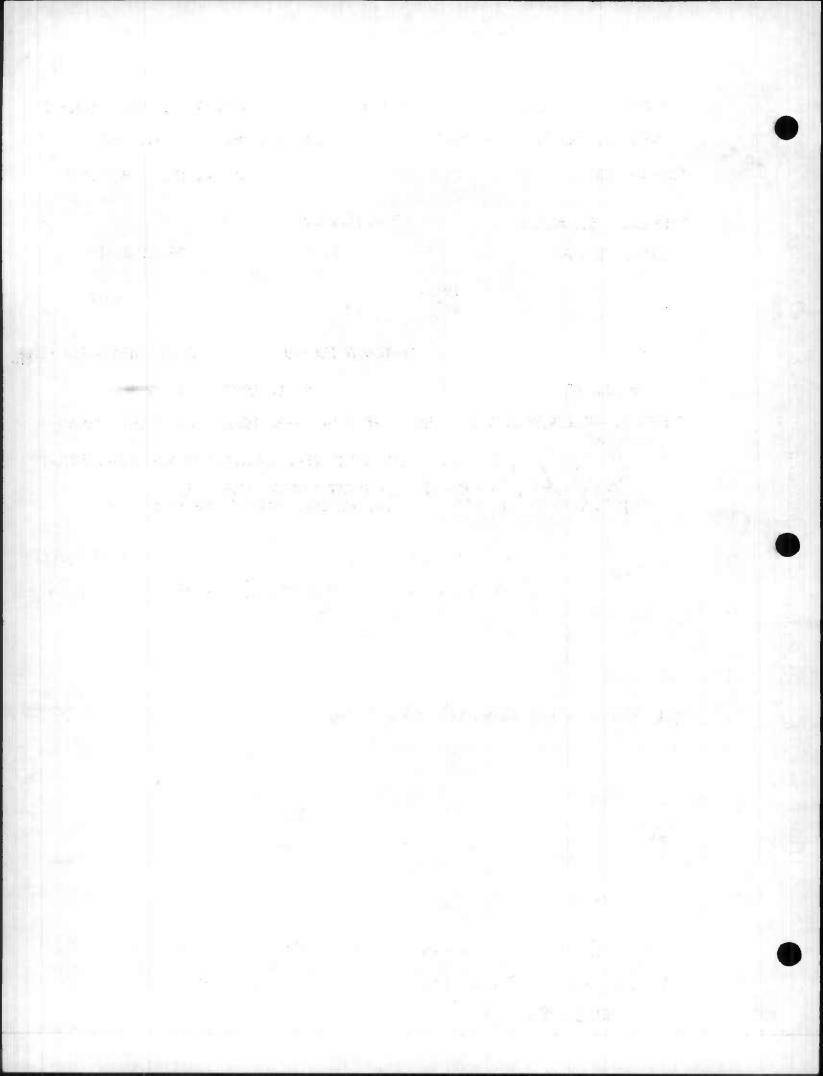
02664 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** JANUARY 20, 1998 MARTIN WILLIAM **BUCKLER** 12:25 AM /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** CHARLOTTE HALL VETERANS' HOME CHARLOTTE HALL ST. MARY'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funerai 9. Birthplace (State or Foreign 1**X** M 2□ F Days Yrs. 212-20-0263 Director 80 JUNE 4, 1917 MARYLAND Usuel Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 🛛 No Director MARYLAND MECHANICSVILLE ST. MARY'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 29818 LEE ROAD 20659 UNITED STATES Items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 1945— I Yes, Give Year or Dates: 1977 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married "natural", or 1□ Yes 2√ No Completed by Specify: 3 ₩ Widowed 4 Divorced WHITE 1977 traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Health and Mentel Hygiene. int: If Itam 27 Is markad other than " Elementary/Secondery (0-12) College (1-4or 5+) LIEUTENANT COLONEL UNITED STATES AIR FORCE January 20, 1998 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM BUCKLER MURIEL AGNES BUCKLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) JOSEPH W. BUCKLER, SR. / NEPHEW : If Itam 27 I 29818 LEE ROAD, MECHANICSVILLE, MARYLAND 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State permit. Pege Department of Important: If any injury or once. MARY'S CHURCH CEM. JAN.23.1998 BRYANTOWN, MARYLAND 22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC. MARK G BROHAWN MO0053 P.O. BOX 156, WALDORF, MARYLAND

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** DEHY DRATION Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner DISEARE AIZHIEMER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? VEINOUS THEROMBOSIJ 1 Yes 2 No 3 Probably Wnknown pege 2 should be Completed 24a. Was an eutopsy performed? Were autopsy findings evelleble prior to completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical Be 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manuer of Death 1 Deathural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 2 Accident 1 ☐ Yes within 24 hours efter deat To the Funeral Director: 6 ☐ Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide ŏ Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end-title of certifier JAN 20 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swife GB ASHVIKUMAR J PATTL PRESTON SOIL INDUSTRI WALDORF MD INDUSTRIAL PARK DR 20601 31. Date filed (Month, Day, Yeer) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

JAN 2 3



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Daeth 3. Time of Death **Physician** MARGARET ROSEANNE **BUCKLER** JANUARY 21, 1998 1:54 AM /Medical 4a. Facility Nama (If not institution, give street and numbar) 4b. City, Town, or Location of Daeth 4c. County of Daath Examiner PHYSICIANS MEMORIAL HOSPITAL LA PLATA CHARLES 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Deys Hours Min, (Month, Day, Yaar) 5. Social Sacurity Number 9. Birthplaca (Stata or Foreign **Funeral** Months Deys Hours 1□M 2**V**F INDIANA 216-22-2873 Yrs Director FEB. 8, 1925 Usual Rasidanca of Dacedant 10a State 10h County 10c. City, Town or Location 10d. inside City Limits ns 23a or 28a-f show 1 ☐ Yas 2 ☐ No Director MARYLAND ST. MARY'S CHARLOTTE HALL the 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? filed within 72 hours after death with 14755 OAKS ROAD 20622 U.S.A. Completed by Funeral 11. Meritai Stetus 12. Was Decadant Ever in U,S. Armad Forcas? Was Dacadant of Hispenic Origin? (Spacify Yas or No-if Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Biack, Whita, atc. traumatic event, the Medical Examiner. 1 Navar Marriad 2 Married 1 ☐ Yas 2 🕱 No if Yas, Giva Yeer or Datas: Maryland 21215-0020 ŏ 1 ☐ Yas 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced "natural", 16a. Dacedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decadant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry al Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) 11 HOUSEWIFE OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnema) . Pages 1 and 2 should be fill ment of Health end Mental Hant: If Item 27 Ia marked oth lury or other traumatic event Be EVERETTE E. GRIMES LAURA ALICE CLARK 19e. informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) HENRY L. BUCKLER, JR. (SON) 14298 OAKS ROAD, CHARLOTTE HALL, MARYLAND 20622 Baltimore, 20b. Placa of Disposition (Nama of cematary, cramatory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 W Burial 2 Cremation 3 Ramoval from State 4 Donatjor 5 Othar (Specify) Department of Important: If any injury or 1 M Buriat 2 Cremation 3 Linear 4 Donation 5 Other (Specify)

21. Signature of Funcial Service Licensea ST.MARY'S CHURCH CEM. JAN. 24, 1998 BRYANTOWN, MARYLAND THE HUNTT FUNERAL HOME, INC. MARK G. BROHAWN M00053 P. O. BOX 156, WALDORF, MARYLAND 20604 23a. Pert1. Entar the diseesa, or complications that caused the daeth. Do not antar the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarvai Between Onset end Death **Physician** Immediata Causa (Final disaesa or condition rasulting in deeth) /Medical Examiner INSU SSI The law requires that the death certificete be axecuted Sequentially list conditions, if any, leeding to immadiate cause. Entar Undarlying Causa (Disaasa or Injury that initieted evants rasuiting in daeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. ed by the attanding physicien detached for use as the buria 4SCND Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be datach 1 Tee 2 No 3 Probably 4 Unknown Completed by Regal Fosture 24b. Wera eutopsy findings availabla prior to complation of cause of deeth? 24a. Was an autopsy performed? certificate has 2 7 No 1 ☐ Yas 1 ☐ Yas 2 ☐ No or Attanding Physician: Be (25. Was casa referred to madical axaminar? 26. Piaca of Daath (Check only ona) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpetiant 3 ☐ DOA 1 Yas 2 No Othar: 4□ Nursing Home 5□ Rasidanca 6□ Othar (Specify) 2 ours effer death.

Neral Director: Affer this of filled in by the funeral di After this 28a. Date of injury (Month, Day Year) 27. Mennar of Death Certification: 28b. Tima of 28c. injury at Work? 28d. Dascribe how injury occurred 1 Aneturei 2 Accident 5 Pending invastigation 1 Yas 2 No 3 Suicida 6 Could not be datarmined 28a. Piace of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stata) 4 Homicide within 24 hours e To the Funeral E completaly filled Hospital 29a. Cartifiar Cartifying Phyalcian: To the best of my knowledga, daeth occurred at the tima, data and placa, and dua to the ceusa(s) and mannar as steted. Medical 2 | Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred et tha time, data and place, and dua to the cause(s) and manner stated. To the 29b. Signature end titla of cartifier 29c. Licansa number 29d. Data signed (Month, Dey, Year) Romes L'Inclosed This 001923 JAN 21, 1998 30. Name end addrass of parson who complated causa of deeth (Item 23a) (Type, Print) Wasdor & MD 20601 31. Data filad (Month, Day, Year) MD

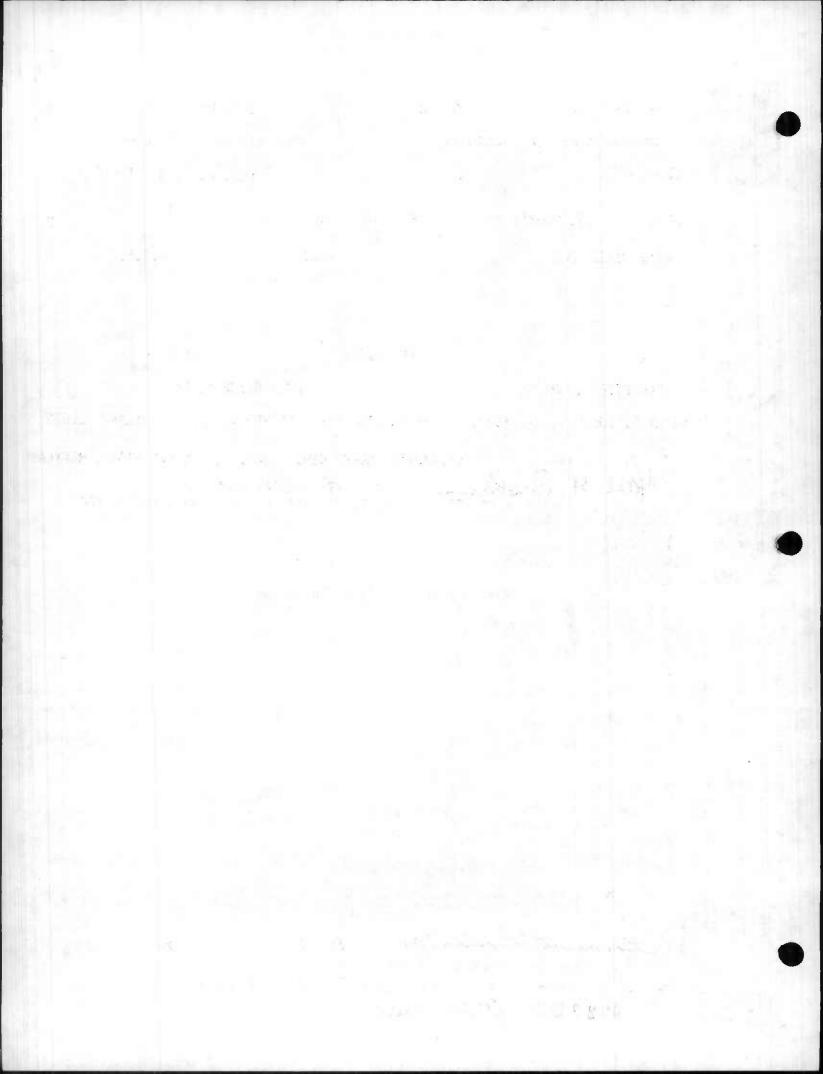
32. Registrer's Signatura

JAN 2 3 1998

DHMH 16 Rev 6/95

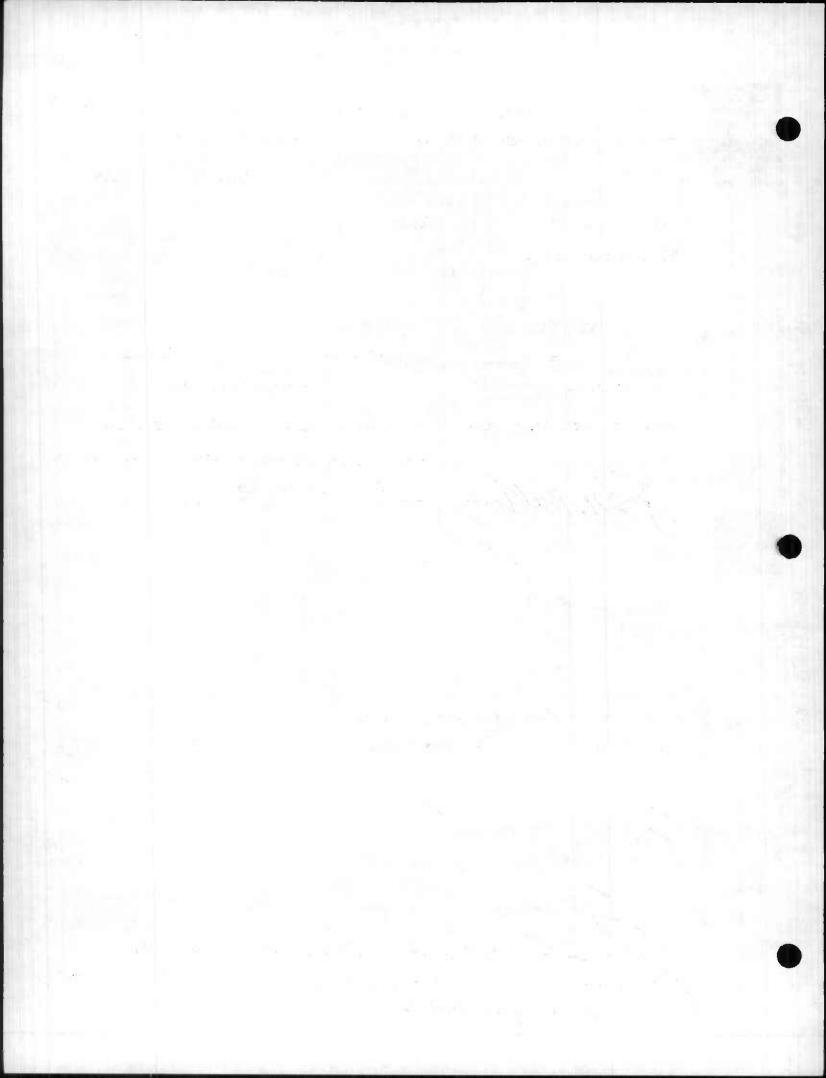
State

Registrar



State of Maryland / Department of Health and Mental Hygiene 8 0 2 6 6 6

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Physicia	an	1. Decedent's Neme (First, Middle, La	st)					2. Dete of D	eeth Dey	Year	3. Time of Dec
/Medic		THOMAS	LUTZ		BARTI	HOLOMEW		Janua		1998	1607
Examin	ner	4e. Fecility Neme (If not institution, giv			men.		4b. City, Town, or SALIS		th 4c. County		
		PENINSULA REGION				If Under 1 Yea					
Funeral Director		5. Social Security Number 6. S 231–10–7156 Usuel Residence of Decedent	IXM 2□F	ge (In yrs. la 84		Months Dey			13	9. Birthple Country Ohio	
* w		10e. State 10b. County		10c. City,	Town or Loca	tion				100	d. Inside City L
or 28a-f show	to	Maryland Wicom	ico	S	alisbu	~v					1 Yes 2
r 28a	Director	10e. Street end Number			uribo u	10f. Zip Code			10g. Citizen of V	Whet Countr	y?
ms 23a or 28a-f show		28753 Ocean Gate	eway			218	01		USA		
or ite	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces' 1 Yes 2 H Yes, Give Yeer or Dates:	?		s Decedent of es, specify Cu Yes 2XN	f Hispenic Origin? (S iben, Mexican, Puer o Specify:	Specify Yes or N to Rican, etc.)	Blac	e - Americe ck, White, et v: Whi	c.
"natural",	Completed	15. Decedent's E	ducetion		16e. Deceder	nt's Usuel Occ	upetion	urkina	16b. Kind of Bu	usiness/Indu	stry
ena. than "n	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)			e during most of wo	nknig			
or th	Con	10	_		Tec	chnicia	1			ronic	5
nd Mental Hygi marked other umatic event,	Be	17. Fether's Name (First, Middle, Last,)						e, Maiden Surnem	16)	
Men	2	Roy Bartholomew					Bertha				
Is m		19e. Informent's Neme/Relationship (et end Number or R				Code)
Dependent of Haalth and Menial Hygiens important: If item 27 is marked other than any injury or other traumatic event, the Magnes.		Jessie V. Bartho	olomew/wii		28755 ace of Disposit		Gateway,	Salisb	20c. Location -		n State
nent of H nt: If ita		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐	Removal from State	Ce	metery, creme	tory or other p				1	
tant:		4 Donetion 5 □ Other (Specif		Spr			y Gardens	1/17/	98 Heb	ron,	MD CIV
Depentr Importu any Inju		21. Signature of Funeral Service Licer	19/10/1		22. N	Name and Add	ress of Fecility Funeral	Home			
LD E e d		ADU K	tal Vou	en	- 50	1 Snow	Hill Rd.	, Salis	bury, MD	2180	4
		23 art /. Enter the disease, or com shock, or heart feilure. List only	plications that cau	dethe death	Do not enter	the mode of d	ying, such es cerdia	c or respiretory	errest,		Approximete ntervel Betwee
hysician			(_							Onset end Dee
/Medical xaminer		Immediate Ceuse (Finel disease or condition resulting in death)	e. 1	SCL						1	10
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64	Physician/						given in Fert i.		Yes 2□ No		
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pen sign		NIDDM	7	nos to	te c				s en eutopsy formed?	24b. Wer	e eutopsy find leble prior to
	Completed	NTEDY						per	TOTHIOG !	com	pletion of caus
是鬼	E O							10	Yes 2 No	10	Yes 22 No
	Be C	25. Wes cese referred to medical					26. Place of De	eth (Check only	one)		
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her this certific nenal director,		2 Accident Investigatio				M 1	☐ Yes 2☐ No				
After	catio	2 Could not b	286. Piece of in	njury - At hor atc. (Specify	me, ferm, stree)	t, fectory, offic	e	28f. Location City or T	(Street end Numb own, Stete)	ber or Rurel	Route Number
ther death. Mrector: After in by the tune	Certification:	3 Suicide 6 Could not be determined	building, 6								
4 hours after death. Furseral Director: After tely tilled in by the tune		4 Homicide determined	hysicien: To the best	of examineti							
4 hours after death. Furseral Director: After tely tilled in by the tune	edicai	29a. Certifier (Check only one)	hysicien: To the best miner: On the basis of end menner s	of examineti tated.	on end/or Inve	stigetion, in my	y opinion, deeth occ	curred et the time	e, date end place,	end due to	the ceuse(s)
ther death. Mrector: After in by the tune		29a. Certifier (Check only one)	hysicien: To the best miner: On the basis of end menner s	of examineti tated.	on end/or Inve	stigetion, in my	y opinion, deeth occ	curred et the time	e, date end place,	end due to	the ceuse(s)
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State of Maryland / Department of Health and Mental Hygiene

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ician		Decedent's Nama (File	rst, Middle, L	Last)						2. Date of D Month	eath Day	,	Year 3.	Time of Death
dical					Jos	eph		BOWM		Januar	16,	199	98	8:30 an
niner	4	la. Facility Name (If not	institution, g	jiva street and	d number)				4b. City, Town,	or Location of Dea	th 4c.	County	of Deeth	
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al or		5. Social Sacurity Numb 579 07 3179		. Sex 1 ☑ M 2□		n yrs. last birti Y		Inder 1 Year oths Days		in. 8. Date of Bi (Month, 9 Aug. 7	rth ay, Year).	15	9. Birthplace Country) Wash	(State or Foreig
		Usual Rasidence of Dec 10a, State 10b	adent c. County		10	c. City, Town	or Location						104 1	nalda Olta i imit
tor	1	MD 100	Calve	rt		Dunki		1						nsida City Limit I □ Yes 2 🖺 N
Director	1	10e. Street and Number					10	f. Zip Code			10g. Citi	zen of W	Vhat Country?	
		11216 Oakwo	ood Dr	ive				20754			US	SA		
Funeral	1	11. Marital Status 1 Navar Married	2☐ Married	Arme	Decedent Eve of Forces? Yas 2 No s, Give	r in U,S.				(Specify Yes or N erto Rican, atc.)	0-	Blac	e - American ir k, White, etc.	
d by		3 ☑ Widowed 4 □	Divorced	Year	or Dates: 19			es XX No				Specify	whit	te
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7		19a. Informant's Name/				106	Moiling Add	drace (Street		Rural Route Numi				(a)
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	2	20e. Method of Disposition		,	2	20b. Place of	Disposition	(Name of		Date	20c. Lo	cation -	City or Town,	State
		ty⊟xBurial 2 ☐ Cre 4 ☐ Donation 5 ☐			rom Stata	Maryla	nd Ve	terans	Cem.	1-22-98	Che	elte	nham, 1	MD
	100	21. Signature of Fugeral					22. Nam	ne and Addre	ss of Facility			-		
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net r	1	shock, or hear failt Immediate Cause (Final disease or condition resulting in death)			Chro		ot enter the	mode of dyin	ng, such as card	me, Owi	arrest,		App	oroximete rval Between set and Death
Examiner	o r	Immediate Cause (Final disease or condition resulting in death) Sequantially list condition fany, leading to immed cause. Enter Underlying Ceuse (Disease or Injury that initiated events			Chro Due	e to (or as a co	Obside on sequence on sequence	mode of dyir	ng, such as card	liac or respiretory	arrest,		App	oroximete orval Between set and Death
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 266

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death Day 11,1998 **Physician** Richard Butler January 0945 am /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Calvert Memorial Hospital Prince Frederick Calvert 8. Data of Birth (Month, Dey, Year) Nov. 29, 1921 5. Social Security Number 6. Sex 1 XM 2 ☐ F If Under 1 Yeer If Undar 24 Hrs. 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 218-14-4922 76 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other then "naturel", or items 23a or 28a-f show other treumstic event, the Madical Exactors must be notified at 1 ☐ Yes 2 No Director Maryland Calvert Lusby 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 395 Sollers Wharf Road 20657 USA Funeral death 12. Was Decedent Ever In U,S. Armad Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puarto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black. by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Deperment of Health and Mental Hygiene. Important: if item 27 is merked other then any injury or other traument. Elementary/Secondery (0-12) College (1-4or 5+) Handyman Odd Jobs 6 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Unknown Mary 2 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Irene Savoy/Sister 1118 Clark Ave. Waldorf. MD 20602 20b. Plece of Disposition (Neme of cametary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Ernestine Jones Cemetery 1/19/98 Chesapeake Beach, MD 22. Name end Address of Facility Sewell Funeral Home 21. Signature of Funaral Service Licensae 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heert feilure. List only one ceuse on each line. Approximata Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final A cute disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Uro sapsis The lew requires that the death certificate be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): and burial-tran physician at the burial P.O. Box 68760. Baderenia Jrom (-) Physician/Medicai Due to (or as a consequence of) Se esn signed by the attending Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown eviluas Records, ð 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed peen CHEF page 2 hes 1 Yes 2 No 1 Yes 2 No After this cartificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this cartifice 25. Was cese referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Dispetient 2 ER/Outpetient 3 DOA Dete of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: after death. 5 Pending Invastigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Deould not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner es steted.

Medical Exeminer: On the best of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceusa(s) end menner stated. 29e. Certifier tely 29b. Signature and title of certifiar 29c. License number 29d. Dete signed (Month, Day, Year) 1-11-78 MD 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Dhiren H. Shah, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State

This Houseon Rowlatt

Registrar

The contract of the contract o

State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey 1 0 Month **Physician** Henry January 1998 Andrew Cummings 1:00 PM /Medical 4e. Fecility Name (If not institution, give street end number, 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Genesis ElderCare - The Pines Easton Talbot. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** M 20 F Deys 73 Yrs. 218-12-1244 Director MAY 24,1924 MARYLAND Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No TALBOT WITTMAN 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 230 8926 NEW ROAD 21676 USA Funeral death Items : 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Stetus 72 hours efter 1 Never Married Married Baltimore, Maryland 21215-0020 ŏ 1 ☐ Yes 2 ☑ No Specify: WHITE þ Specify 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. permit. Pages I and 2 should be filed within Department of Health and Mantal Hygiene. Important: if from 27 is marked other than eny Injury or other traumetic acceptants. Elementery/Secondary (0-12) College (1-4or 5+) WATERMAN COMMERCIAL -0-17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) ANDREW CUMMINGS ANNA MARIA RIMMER 19e, Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 33, WITTMAN, MD 21676 PEARL E. CUMMINGS/ WIFE 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremetion 3 ☐ Removel from State WOODLAWN MEMORIAL PARK 1-13 EASTON, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MARYLAND

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximate Approximete intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Final CARCINOMA diseese or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest and Due to (or as e consequence of): Box 68760 attending physician The law requires that the death certificate be Physician/Medical the Due to (or es e consequence of): jo P.O. signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown RUEMONARY VISEAGE Records, by Completed DIATION INENMONITIES 24b. Were eutopsy findings eveilable prior to 24e. Was en eutopsy performed? peeu completion of cause of deeth? has 1 Yes 2 J No 1 ☐ Yes 2 ☐ No certificata Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; 25. Wes cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4th Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28c. Injury et Work? 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piace, and due to the cause(s) end menner stated. Medicai 29e. Certifier 29b. Signeture and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 1/12/98 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

800 S

ST ST MICHAUS MD 21663

State

Registrar

BREMUR

JAN 12 1998

MD

32. Registrer's Signeture

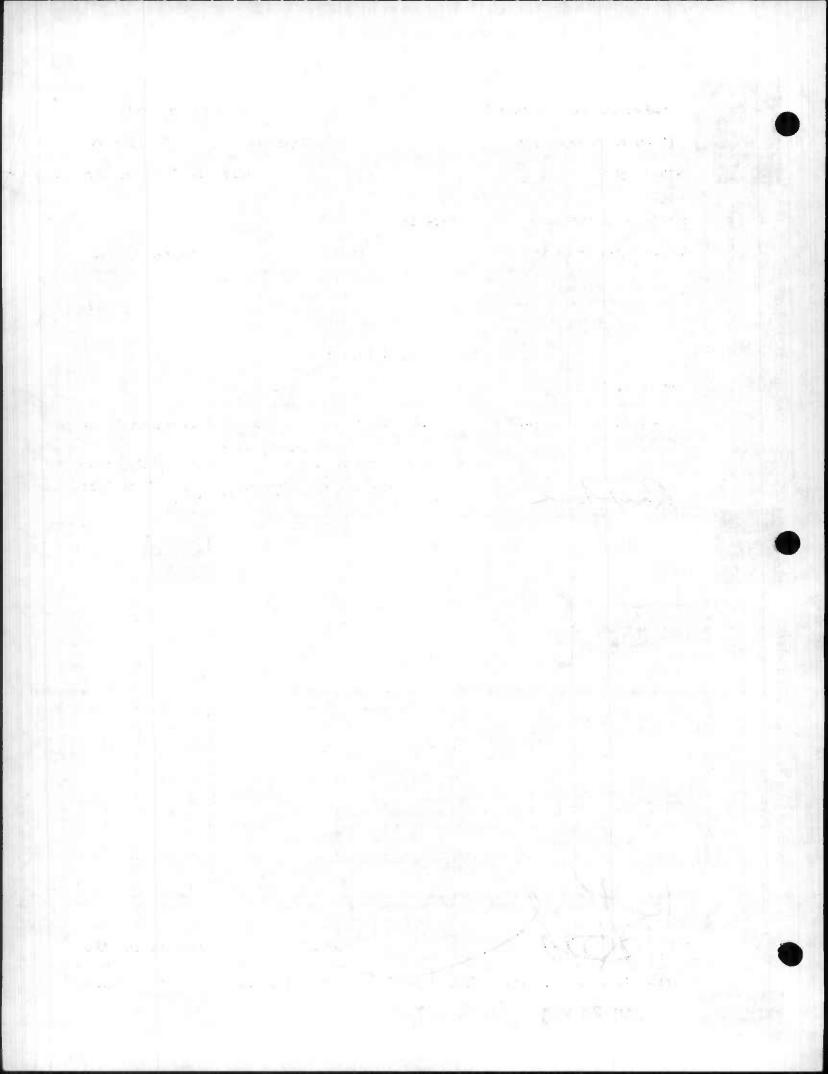
Julia Davidson

WILLIAM

31. Dete filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

	Decedent's Neme (First, Middle, La	st)		Cer	tificate (of Death		2. Dete of Dea	Reg. No.	W 6	Time of David
ian	Evalyn Frances		a					Month Januar	Dey	Year 998	9:15AM
ical ner	4e. Fecility Neme (If not institution, give					4b. City, To	wn, or Lo	cation of Deeth	1		9:13AM
	16940 Baederwoo				WIL 1		rwood			tgomery	
	5. Social Security Number 6. S 578-24-5938 Usuel Residence of Decedent	M 2∭ F	72	last birthday) Yrs.	If Under 1 You Months De	ear If Under eys Hours	A.Airo	8. Date of Birt (Month, De July 23	, Yeer) , 1925	9. Birthplece Country) Washin	gton, D
	10e. Stete 10b. County		10c. Ci	ty, Town or Lo	cation					10d.	Inside City Limi
ctor	Maryland Montgom	ery	De	erwood							1 ☐ Yes 2 ☒ N
Director	10e. Street end Number				10f. Zip Coo				10g. Citizen of		
era	16940 Baederwood	Lane 12. Wes Deceden	. 5	0 10	208		1.010		United		
by Funeral	11. Maritel Status 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces 1 Yes 2 High Yes, Give Yeer or Dates	? I No		Yes, specify (of Hispanic Orl Cuben, Mexican No Specify:		Ricen, etc.)	Specif	ce - Americen I ck, White, etc. V: White	
ted	15. Decedent's Ed	ducation		16e. Deced	ent's Usuei Oc	cupetion	a La collinada		16b. Kind of B		
Completed	(Specify only highest green Elementery/Secondery (0-12)	College (1-4or	5+)	life. D	OO NOT use re	ne during mos tired)	t of workin	ng .			
	17 Fother's Name (First Middle Least	2		Lega	al Secr			(F) . AE . II	Law		
Be	17. Fether's Neme (First, Middle, Last) Harry W. Burch								Meiden Sumer	ne)	
2	19e. Informent's Neme/Reletionship (Type, Print)		19b. Meilin	o Address (Str			. Smith	r, City or Town	State Zin Co	r(e)
	Vincent A. Campane			614 Tı	rixsam	Road, S	Sykes		Maryla		
	20e. Method of Disposition		20b. F	Place of Dispos	sition (Neme of	plece)Jan.	17	Date	20c. Location		
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	d	Das	1-1	Mamara	1 D 1	1	1998	Rockvil	le Ma	rvland
	21. Signeture of Funeral Service Licental 500	MOO	Ro. 3	Name end Ad bert A. 800 Wes	dress of Fecilit Pumph: t Montg	rey F	Suneral y Avenu	Home/R	ockvil	le, Inc	
	23a. Pert1. Enter the disease, or com-	plications thet cause	d the deet	h. Do not ente	CCKVII or the mode of	le, Mar dying, such es	ylani cardiac o	2085 r respiretory er	0-2805 est,	Ap	proximete
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Physician/	Part II. Other significant conditione of	ontributing to death	out not res	uiting in the un	derlying ceuse	given in Pert I.		23b. Dld to	obacco uee co	ntribute to the	cause of deat
								1 🖾 ነ	es 2□No	3 Probabl	y 4 □ Unkno
Completed by								24a. Wes e		evelleb	outopsy finding le prior to ation of ceuse h?
mo								1□ Y	es 2⊠No	1 □ Ye	
Be	25. Wes cese referred to medical examiner?					26. Place	of Deeth	(Check only or	ne)		
2	1 ☐ Yes 2 ☒ No			ER/Outpatient	ODDON		rsing Hom	e 5 🖾 Resid	ence 6 Oth	er (Specify)	
Certification:	27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year)	28b. Time of Injury		njuryet Work? □ Yes 2 □ i		8d. Describe h	ow injury occur	red	
Certiff	3 Sulcide 6 Could not be determined	28e. Plece of In building, e	jury - At ho c. <i>(Specif</i>)	ome, farm, stre	et, factory, offi	СӨ	2	8f. Location (S City or Tow	treet end Numb n, Stete)	er or Rurel Ro	ute Number,
edical	29a. Certifler Medical Exam	sician: To the best inet: On the basis of	of examine	wledge, deeth	occurred et the	time, dete end	d plece, er	nd due to the c	euse(s) end me ate end place,	onner es steted	l. ceuse(s)
400	290. Signature and title of certifier	end menner s	ated.		-	ense number					-
	A CONTRACTOR	4							9d. Date signe		
1	No Named of Street	/ Amelated as a second	1	09=1 47	110-23	02143		J	anuary	10, 19	98
	30 Name and appress of person who can be a Barton J. Gershen			Shady		Pond P	ocky	i110 M	a w. 1 a a à	2005	^
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month ARlesimo Francis 0530 4a. Facility Nama (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Deeth PRINCE If Under 1 If Undar 24 Hrs. ANO RORGES 5. Social Security Number 9. Birthplaca (Stata or Foreign Country) New York State 8. Date of Birth January Aga (In yrs. last birthday Days Months Hours 1 € M 2 □ F 74 071-18-5274 Usuel Residence of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No New York Oneida Utica 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 910 Bleecker Street 13501 United States 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva Yeer or Dates: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, atc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. White 3 ☐ Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Reverend Catholic Priest 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Carlesimo Pasgual Alessandrini Colobove 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) /sister Anne Sgroi 910 Bleecker St., Utica, New York 13501 20e. Method of Disposition 20b. Pleca of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Anthony's 1-16-98 Fredonia, New York 21. Signature of Funeral Service Licensi 22. Nama and Address of Facility Hines- Rinaldi Funeral Home, Inc., 11800 New Hampshire, Ave., Silver Spring, Md. 20904 23a. Pert1. Enter the disease, or completitions that shock, or heart failura. List only one ceuse on death. Do not enter the moda of dying, such as cardiac or respiratory arrast, with hetester Immediete Ceuse (Final diseesa or condition resulting in death) (or as a consequence of): stray (or as a consequence of): Dua to (or es e consequance of):

Physician /Medical Examiner

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ate hes been signed by the page 2 should be detached

this certificate

s efter dea...

To the Hospital within 24 hours of To the Funeral Completely filled

director, Be

2

Certification:

Medical

or Attending Physician: The lew requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

permit. Pege Department of important: if eny injury or once.

Physician

/Medical

10a. State

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed by

Be

7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Modical Examinar must be notified at

i Hygiene.

. Peges 1 and 2 should be fill ment of Heelth and Mentel Heart: If item 27 is marked oth jury or other traumatic even

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Physician/Medical þ Completed

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2VI No 3 □ Probabiy 4 □ Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings eveilabla prior to completion of cause of deeth?

1 🗆 Yas

26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yas 2 ☐ No

25. Wes case referred to medical examiner? 1□ Yes 20 No 27. Menner of Deeth

5 Pending investigation

6 Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year)

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28c. Injury at Work?

題

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

29a. Certifier

Neturel
Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et tha time, date and plece, end due to the ceuse(s) end menner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Slonatura and title of certifiar

d. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

29c. Licansa number

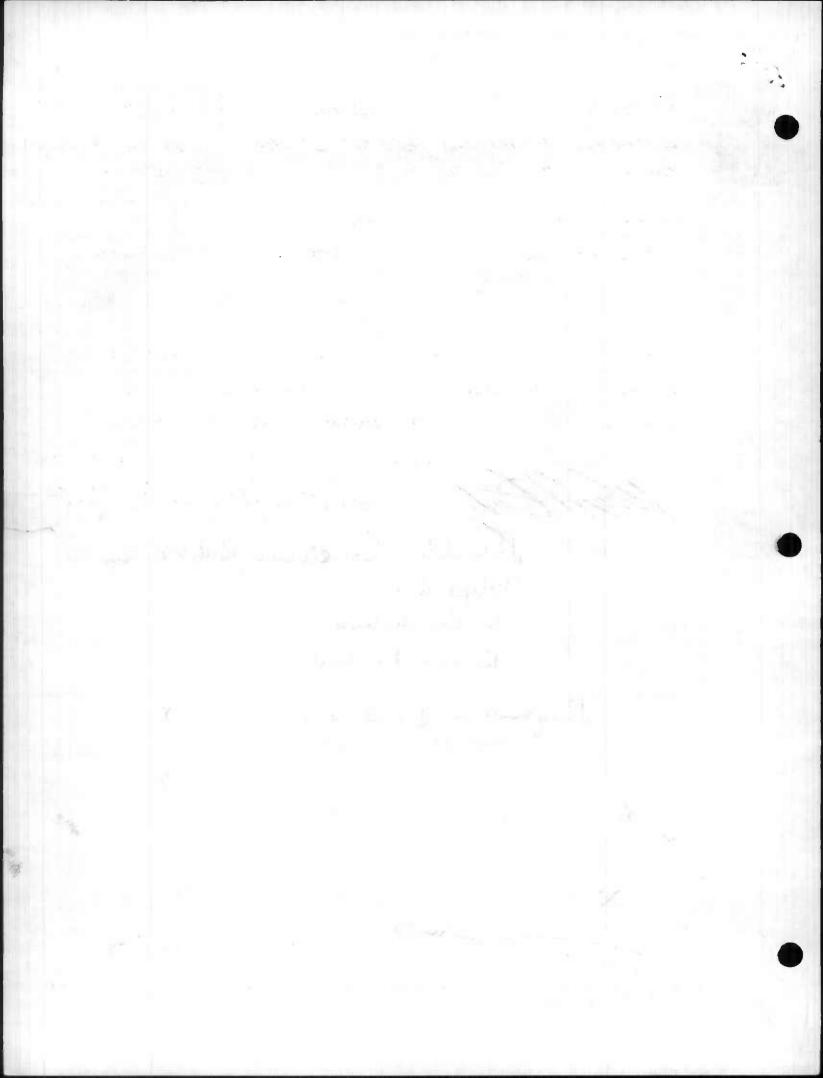
29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

austanez. MD 31. Dete filed (M)

1300 MereauTile lane , landorer 32. Begintrer's Signatura

State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death **Physician** DOBERT 4b. City, Town, or Location of Deeth / 4 /Medical 4c. County of Deeth 4a. Fecility Neme (If not institution, give street and number) **Examiner** Takoma Park Washington Adventist Hospital Montgomery 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year)
April 3, 1917

8. Birthplece (Stet Country)

April 3, 1917 6 Sax Birthplece (State or Foreign Country) **Funeral** 1₩ 2□ F Months Days Hours Min Yrs. 80 Director 216-07-3993 Usuel Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Prince George's Hyattsville 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 3912 Calverton Drive 20782 USA 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yas, Giva
Yeer or Dates: WWII Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status 14. Race - American Indien. Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Tyes 2 No Specify: p 3 Widowed 4 Divorcad White Completed 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry d 2 should be filed within the end Mental Hygiene.
7 Is marked other than "r Service Stations/ Elamentary/Secondary (0-12) Collaga (1-4or 5+) Owner/Manager Real Estate Investments 4 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumame) Be permit. Peges 1 end 2 should be Department of Health end Mental Important: If Nem 27 is marked o any Injury or other traumatic eva James A. Chaney Mary E. White 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary Charlotte Chaney (wife) 3912 Calverton Drive, Hyattsville, MD 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 1/23/98 Alexandria, VA Francis J. Collins Funeral 22. Name end Address of Fecility Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 23e. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one cause on aech lina. Approximata Intervel Between Onset and Death **Physician** e. SEVERE MITRAL REGARGITATION.

Due to (or es a consequence of): /Medical Immediate Ceuse (Finel disease or condition resulting in death) **Examiner** Examiner HYPERTENSIVE HEART DISEASE The law requires that the death certificate be executed physician and the burial-tran Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) for use es Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? the 5 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed be del Records, by 24b. Wara autopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? hes le 2 page 1 Yes 2 No certificete 1 Yes 2 No Division of Vital al or Attending Physician: Ti s efter death. Il Director: After this certificat ed in by the funeral director, pa 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 1 Yes 2 No Certification: To 28e. Data of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No Investigetion 2 Accident 3 Suicide 6 Could not be determined 28a. Placa of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours of To the Funeral DI completely filled in in 24 hours of the Funeral Di pletely filled in edicai Certifying Physician: To the best of my knowledga, daath occurred et the time, data end place, and dua to tha causa(s) and mannar as stated.

| Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, daath occurred at tha tima, data end placa, and dua to tha cause(s) end menner statad. 29a, Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14364 70+1 30. Name and address of person who completed cause of death. Item 23a) (Type, Print)

76/0 Carroll Ave#300 Takoma Park. Md, 20912

State Registrar

M.H. CHAUDHRY 31. Date filed (Month, Day, Year)

JAN 21 1998

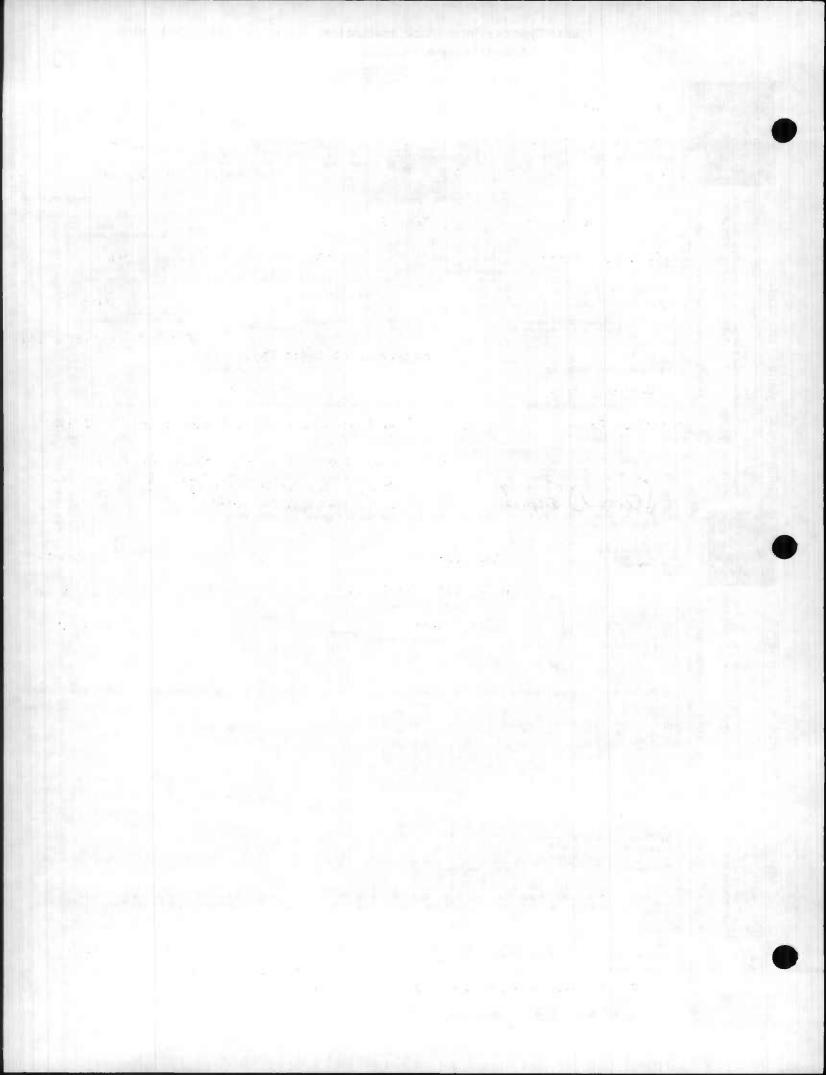


	Decedent's Name (First, Middla, Last)			Ce	rtificate	or Dea	21//	2. Data of De	Reg. No.		3. Time of Deeth
n	Jean E. Cline							Month	Dey	Yeer	11:48 AN
al	4a Facility Nama (If not institution, giva s	street and number)				4b. Cit	y, Town, or	Location of Deat			11.40 A
er	4406 Kalmia Stre						kvill		Monte		17
	5. Social Sacurity Number 6. Sex	7. Aga	(In yrs. la	ast birthdey)	If Under 1	Year If U	ndar 24 Hrs	8. Data of Bi	th		eca (State or Forei
	579-24-4886	M 2回F	72	Yrs.	Months	Days Ho	urs Min	Aug. 2		Wash	ington, I
	Usual Residence of Decedant 10a, State 10b, County		10a Cibi	, Town or Lo	nestina					14	Od Jooldo City Limit
2			Too. Oily,								Od. Insida City Limit 1 ☐ Yas 2 ☑ N
Director	MD Montgome:	ry		Rocky	10f. Zip C	ode			10g. Citizan ot V	What Count	m.2
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Funeral	4406 Kalmia Stree	C I2. Wes Decedent E	ver in U.S	3. 13.		0853	c Orlgin? (5	Specify Yes or No	- 14. Race	USA - America	an Indian.
E L	1 Navar Married 2 Married	Armed Forcas? 1 ☐ Yas 2 ☑ N			It Yas, specify	Cuban, Ma	xican, Puer	rto Rican, atc.)		k, Whita, a	
þ	3 ☐ Widowed 4 ☐ Divorced	It Yas, Giva Yaar or Datas:			1□ Yas 21	No Sp	ecify:		Specify	Wh	ite
Completed	15. Decedant's Educ	cation		16a. Dece	dant's Usual (Occupation		and to an	16b. Kind ot Bu	sinass/Ind	lustry
ğ	(Specify only highast grade Elamantary/Secondary (0-12)	Collega (1-4or 5-	+)	lifa.	kind of work DO NOT usa	ratired)	most of we	NKIII	Own Home	Pub.	lic Schoo
5	12		E	Homema	ker/Ca						
Be	17. Father's Neme (First, Middla, Last)					18. [Aothar's Na	ma (First, Middle	, Maldan Sumam	a)	
2	Charles Stokes						Emma '				
	19a. Intormant's Name/Ralationship (Typ								er, City or Town,		Coda)
	Robert A. Cline	(son)					Aven	ue, Pool	esville,		20837
	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ R.	amoval from State			osition (Name matory or othe		=_/ -				
	4 □ Donation 5 □ Othar (Specify)		For		coln C				Brentwo		
	21. Signature of Funaral Sarvica Licansa	0		H	2. Nama and . Iome, I	Addrass of I	500 U	Francis niversit	J. Colli y Blvd.	ns Fi West	uneral
	teven to	ond			ilver						
	23a. Part1. Entar tha disaasa, or complication shock, or haart failura. List only on	cations that caused a causa on aach line	the daeth. a.	. Do not en	tar the moda	ot dying, su	ch as cardia	c or respiratory a	irrast,	1	Approximete fntarval Batwaan Onsat and Death
	In a dieta Course (Final									1	Onsat and Death
	Immediata Causa (Final disaasa or condition rasulting in daath)	Liver	Fail	ure							2 months
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	_ b	Metasi								113	8 months
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8	rasulting in daath) Lest		206 (0)	as e consec	querica oi).					1	
Physician/M	d										
200	Part II. Other significant conditions con	tributing to death but	t not rasul	Iting In tha u	undarlying cau	sa given In	Part I.	23b. Did	tobacco use cor	ntribute to	the cause of dea
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by											
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Completed											nplation of cause death?
5								10	Yas 2 No	10	Yas 2□ No
0	25. Was casa ratarrad to medical axaminar?					26.	Placa ot De	eath (Check only	ona)		
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eruncation:	2 Accident invastigation 3 Suicide 6 Could not be				М	1 Yas	2 □ No		(0)		t Marsha At a fear
	4 Homicida dataminad	28a. Place of Inju- building, atc.	ry - At hor . (Specify)	ma, farm, st)	reat, factory, o	office			(Streat and Numb wn, Stata)	er or Hura	r Houte Number,
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DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month **Emily** Brown Collins Jan. 12,1998 5:30 A.M. /Medical 4e. Fecility Nama (If not institution, giva straet and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 4701 Willard Avenue #821 Chevy Chase Montgomery | If Undar 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Dec. | 8, 1920 5. Social Security Number 9. Birthplece (Stata or Foreign Country) unavailable 7. Age (In yrs. lest birthdey) **Funeral** 1 ☐ M 2 🖾 F Yrs. 415-01-5086 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 No Maryland Montgomery Chevy Chase 10e. Street end Numbar 10f. Zip Code 10g. Citizen of What Country? 4701 Willard Avenue #821 20815 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 No If Yas, Give Yeer or Datas: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 72 hours after 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: à Specify: 3 Widowed 4 □ Divorcad white Completed 15. Decedent's Education 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest greda completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 Is marked other th any Injury or other traumetic event U.S. Government accounting technician 17. Fethar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be unavailable unavailable 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Steven J. Bienstock /attorney 401 E. Jefferson St., Rockville, Md. 20850 20b. Place of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 1/13/98 4 Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Va. 21. Signature of Junerel Service Licensea 22. Neme and Address of Fecility DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., DC 20007 234. Part1 Enter the disease, or complications that caused the deeth. Do not anter tha mode of dying, such as cardiac or raspiratory arrast, shock, or head feilure. List only one ceuse on eech line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Emphysema 30 years Examiner Due to (or es a consequence of): Examiner physician and s the buriai-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Dua to (or es e consequence of): Box 68760. Physician/Medicai Due to (or es e consequenca of) ettending g P.O. | Part II. Other aignificent conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by (1 ☐ Yes 2 ☐ No 3 A Probably 4 ☐ Unknown Diabetes mellitus Records, þ Completed 24b. Were eutopsy findings evallable prior to 24a. Was an eutopsy performed? peen complation of cause of deeth? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours eftar death.

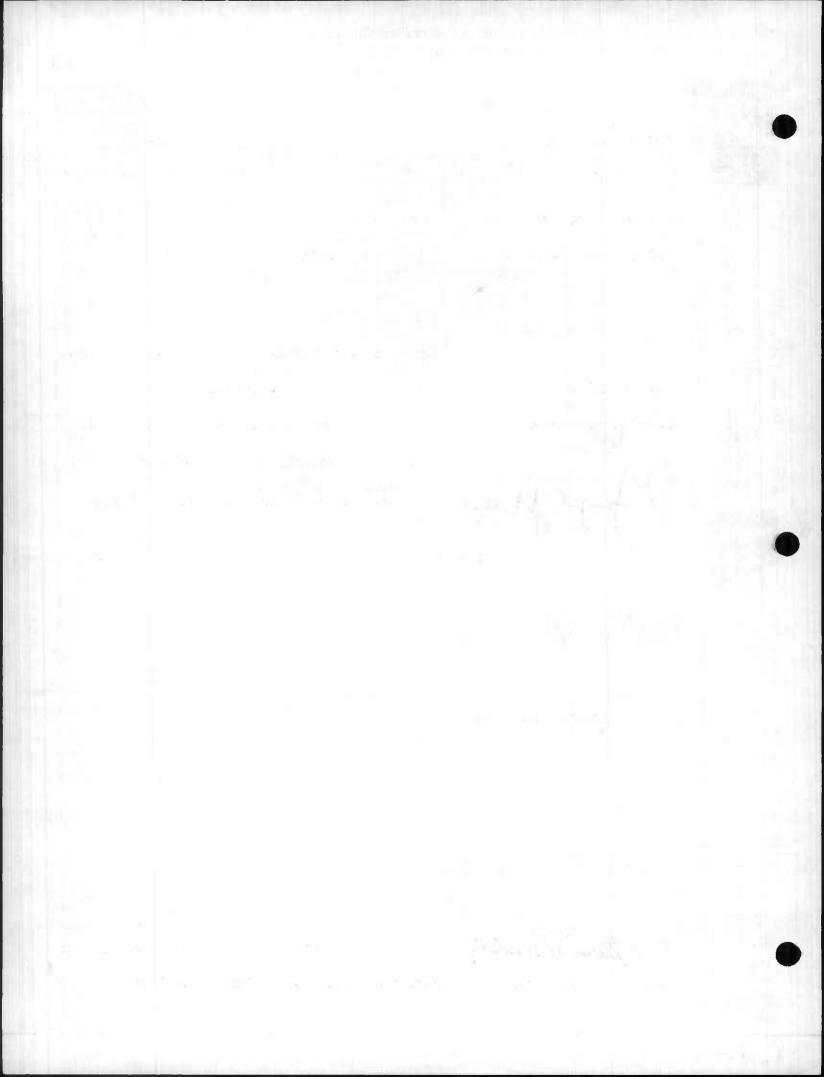
To the Funeral Director: After this certifica completally filled in by the funeral director, 25. Was cese rafarred to medicel Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 【XResidence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Medical 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of examinetion end/or Investigation, in my opinion, death occurred et the time, dete end piace, end due to the ceuse(s) end manner stated. 29a, Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) D20297 January 12,1998 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 4701 Willard Ave., #224, Chevy Chase, Md. 20815 James Brodsky, M.D., 31. Data filed (Month, Day, Year)

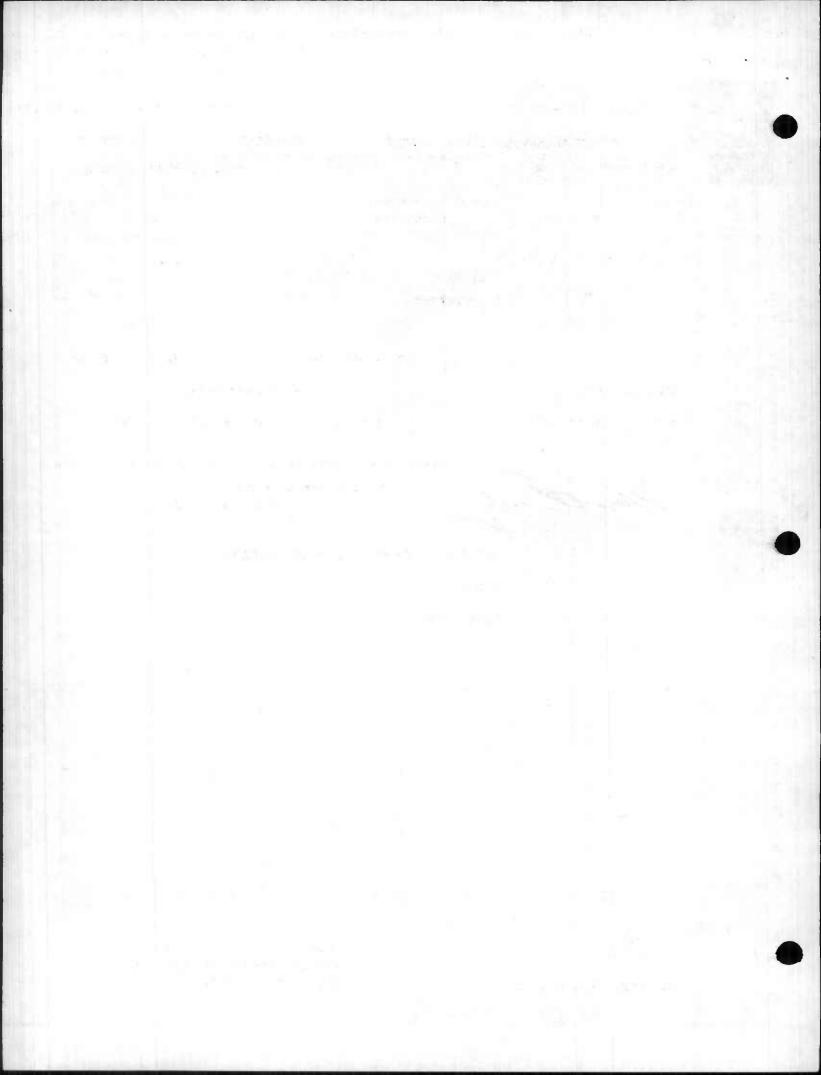
JAN 22 1 32 Registrar's Signature State ha Davidson-Randell Registrar

DHMH 16 Rev 6/95

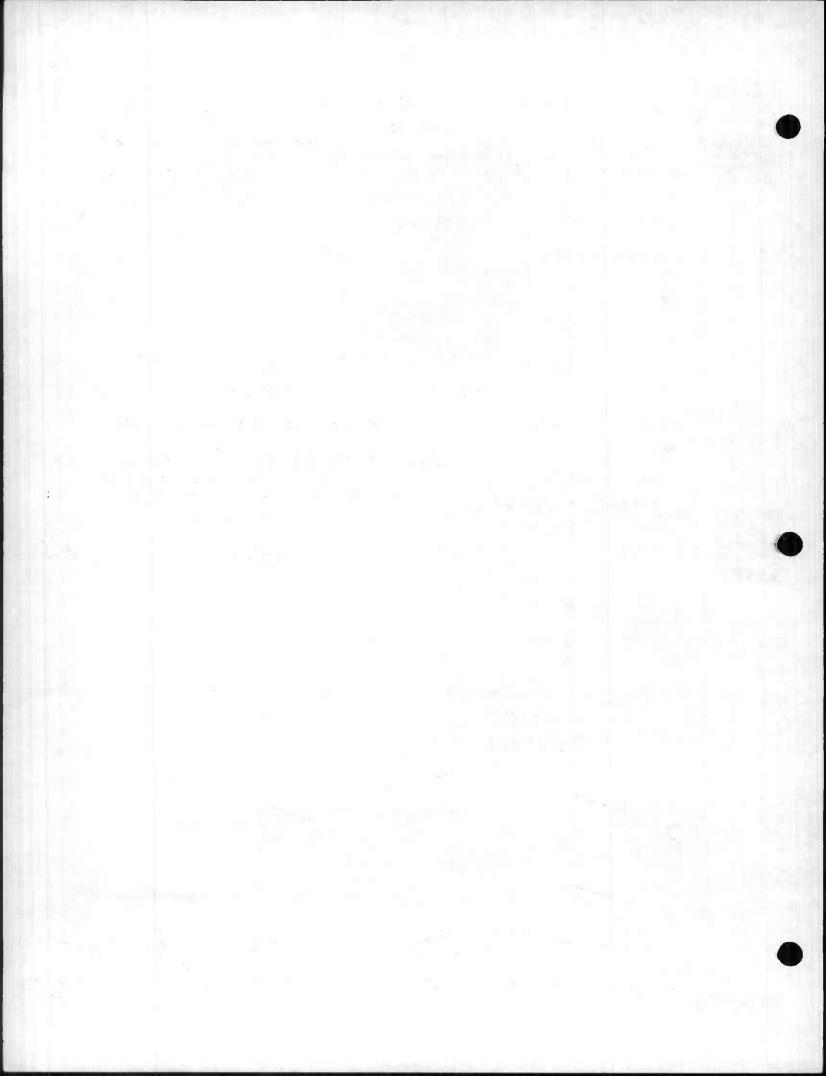
29d - Informand had difficulty obtaining Info. fee. F. H.



State of Maryland / Department of Health and Mental Hygiene, Amend #12,1/26/98, BMw, Montg. Co Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day 1998 **Physician** 7 DONALD HUGH CURRY JAN 12:50 PM /Medical 4e. Fecility Neme (If not institution, give straat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Undar 24 Hrs. Hours Min. 8. Date of Birth Person, 22, 1930 5. Social Sacurity Number 9. Birthpiece (State or Foreign Michigan 7. Age (In yrs. last birthday) **Funeral** Months Deys 366-28-8388 10XM 2□ F 67 Director Usual Rasidenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location rai', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Fairfax Chantilly 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 14511 Braniff Circle Funerai U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Q4 7. 14. Rece - Amarican Indian, 11. Marital Status Black, White, etc. 72 hours efter Baltimore, Maryland 21215-0020 1 Never Married 2 Married White "natural", or þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Health end Mental Hygiene. Important: If them 27 is marked other than "n any injury or other traumatic event, are Heal once. Elamantary/Secondary (0-12) College (1-4or 5+) 12 Tech. Sergeant U.S. Air Force 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Sumame) Be 2 Hugh L. Curry Laura Anna Wells 19a. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Straet end Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Curry (Wife) 14511 Braniff Circle Chantilly, VA 20151 20e. Method of Disposition
1 Burlei 2 □ Cremetion 3 □ Removal from Stete 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Steta Data 4 ☐ Donetion 5 ☐ Other (Specify) Arlington National Cem. 1/22/98 Arlington, Virginia 21. Signature of Funerel Sarvice Many 22. Name end Address of Fecility **Everly Funeral Home** 10565 Main St Fairfax, VA 22030 23a. Pert1. Enter tha diseese, or complications to shock, or heart feilura. List only one ceuse ged the deeth. Do not entar the mode of dying, such es cardiac or respiretory errest, Approximata intervel Batw Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical ACUTE RESPIRATORY DISTRESS SYNDROME **Examiner** Dua to (or as e consequence of) Examiner SEPSIS ettending physician end for use as the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events Dua to (or es e consaquenca of): LUNG CANCER Box 68760. Physician/Medicai Dua to (or as a consequence of): resulting in death) Last P.O. ed by the e Pert II. Other significent conditions contributing to death but not rasulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were eutopsy findings evelleble prior to completion of causa of daath? page 2 should Completed 24a. Was an autopsy performed? Yes Yes 1 ☐ Yes ZE No 2 No Division of Vital 25. Wes cese referred to medical exeminer? Be 26. Pleca of Daeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 💢 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Deeth 28e. Dete of injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. injury et Work? or Attending s effer des. 1 XNatural 5 Panding Investigation 1 Yes 2 No 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, straet, factory, offica building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 24 hours 1 XCertifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.
2 Medical Exeminer: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner steted. 29a. Cartifiar To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Data signed (Month, Dey, Yeer) JAN. Y RES-000 NATIONAL NAVAL MEDICAL CENTER 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) BETHESDA MD 20889-5600 TANNA, LT, MC, USN 31. Dete filed (Month, Dey, Year) Registrar's Signeture State 20 1998 lia Davidson Registrar



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/Medical xaminer	_	la. Fecility Nema (If not institution, give street en	d number) MARTN	ER HEALTH	4b. City, Town, or Lo	cation of Death	4c. County of I	Death
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nerai		5. Social Security Number 6. Sex	7. Age (In yrs. lest t	birthday) If Undar 1 Yaar Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De)	h 9.	Birthplace (State or For Country)
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find at	5	MARYLAND N/A	BAT!	TIMORE				1 □XYes 2□
be notified	3	ioe. Street and Numbar	DAU.	10f. Zip Code			10g. Citizen of Whe	et Country?
T P		3712 ROLAND AVENUE		212	211		u	.s.a.
miner must be notified at		11. Marital Status 12. Was	Decedent Evar in U,S. ed Forces?	13. Wes Decedent of H	lispanic Origin? (Spe	ecify Yas or No-	14. Rece -	Amarican Indian, White, etc.
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To F		JOHN 19e. Informent's Neme/Relationship (Type, Print)	O'NEILL	9b. Mailing Address (Street	end Number or Rure		er City or Town Ste	SWAIN
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ial-transit Examiner		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury C		e consequence of):				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month James Crawford 3:31 pm January 17, 1998 /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 713 Marley Avenue Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. lest birthday) **Funeral** Birthplace (State or Foreign Country) Hours 10XM 20 F 234-56-6536 Director Yrs 60 May 26, 1937 W. Virginia Usual Residence of Decedent 10e State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show munt be notified at Anne Arundel Glen Burnie Director MD 1 ☐ Yes 2 ☒ No 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 713 Marley Avenue 21061 items 23a USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. the Medical Examiner should be filed within 72 hours after ond Mental Hyglene. marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☒ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede complated) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) Collaga (1-4or 5+) Builder Construction 12 permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event ORGS. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Surneme) Be Charlette S. Crawford Hezzie Russell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 17 Lanyard Lane, Waterford, CT Jennifer Crawford/daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Jan 21 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☑ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 1998 22. Name end Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD much 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, nock, or heart failure. List only one ceuse on each line. Approximete intervel Between Onset end Deeth Physician Immediate Ceuse (Final disease or condition resulting in daeth) /Medical Examiner Examiner attending physician end for use as the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Undarlying Ceuse (Disease or injury that Initieted events resulting In death) Lest Box 68760. Physician/Medical Due to (or es e consequence of) P.O. 1 Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. been signed by the should be deteched 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Ware autopsy findings eveileble prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed? Division of Vital Hospital or Attending Physician: director, Be 25. Wes cesa rafarred to medicei examiner? 26. Placa of Daath (Check only ona) Other: 4 ☐ Nursing Home 5 █ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Menner of Daath 28b. Tima of 28e. Date of injury (Month, Dev Year) 28c. Injury et Work? 28d. Dascribe how injury occurred After 5 Pending investigation 1 Natural sefter death.

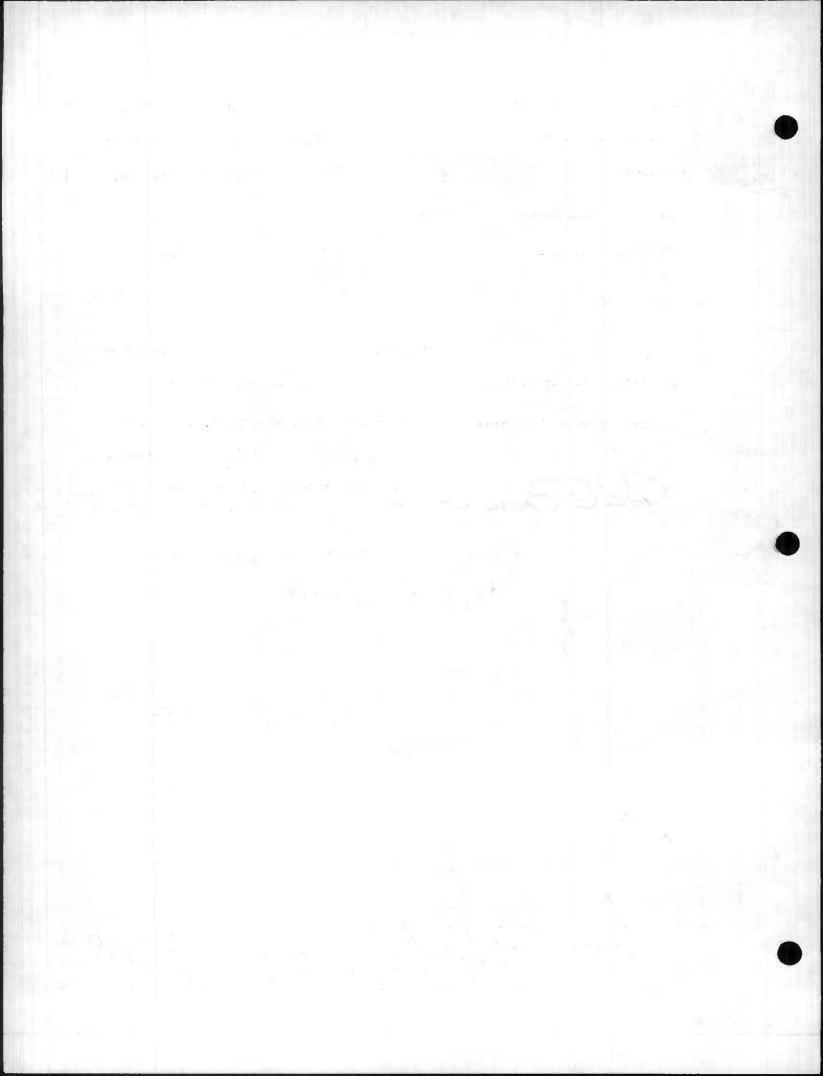
I Director: Aff 1 Yes 2 No 2 Accidant 3 ☐ Suicide 6 Could not be determined 28a. Plece of Injury - At home, farm, straat, factory, office building, etc. (Specify) Location (Straet and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicida To the Hospital within 24 hours e To the Funeral C completely filled edicai 150 Cartifying Phyelcien: To the bast of my knowledge, deeth occurred et the time, data and piace, and due to the causa(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, data end piace, and due to the causa(s) and mannar stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) who complated ceusa of danth (Item 23h) (Typ

State Registrar 15/0

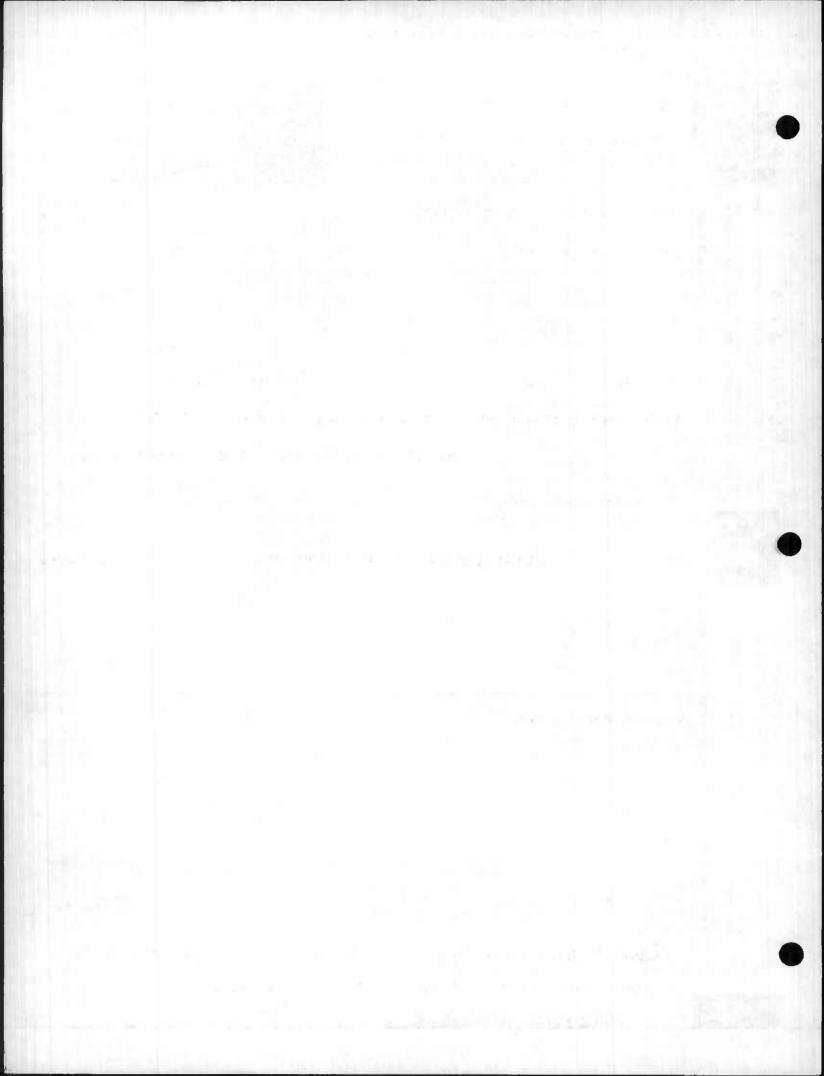
32. Registrer's Signeture

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31. Dete filed (Month, Dey, Year) JAN 2 0 1998



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tor	Md.	Howard		Dayton						1 ☐ Yes 2 🖪 No
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þ		rried 2 Married	12. Wes Decedent Ever Armed Forces? 1 Yes 27 No If Yes, Give Yeer or Detes:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispenic Orlgin? (Sean, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	Blac	a - Americ k, White, white	etc.
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To Be Co		(First, Middle, Last, 1bert Tho				18. Mother's Ner	me (First, Middle es Elean	n, Meiden Sumem or Ridge	ely	
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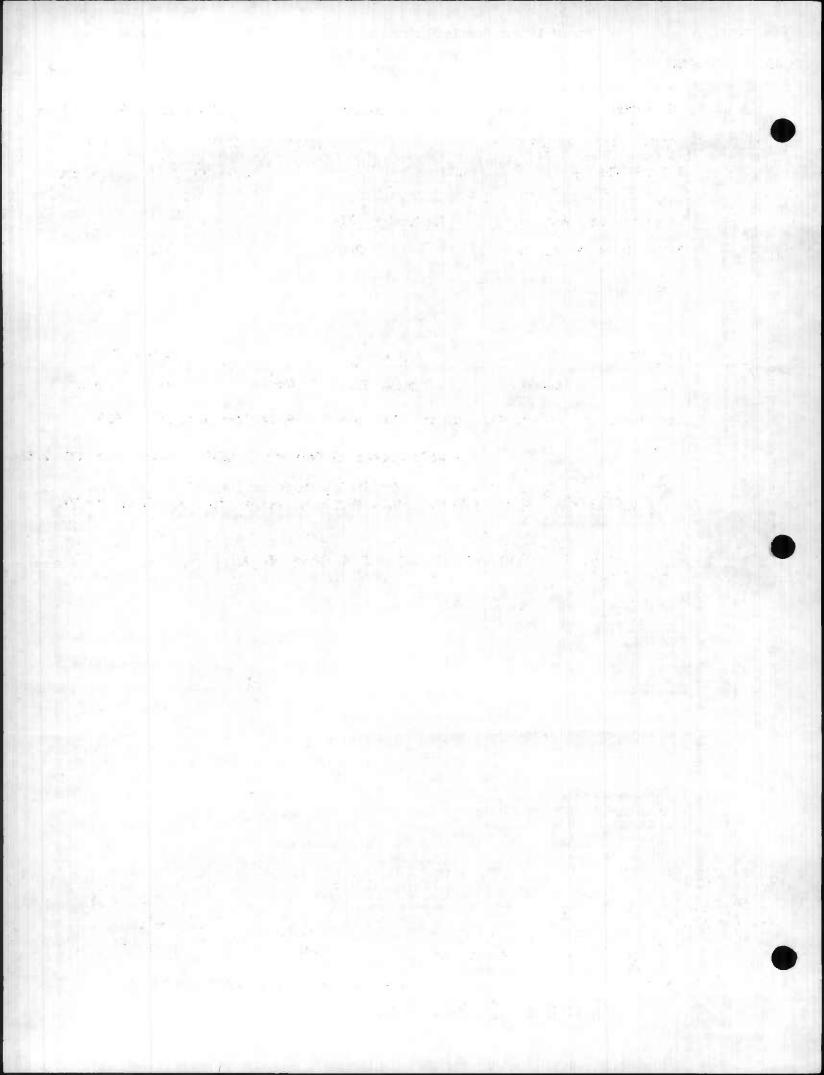


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State of Maryland / Department of Health and Mental Hygiene

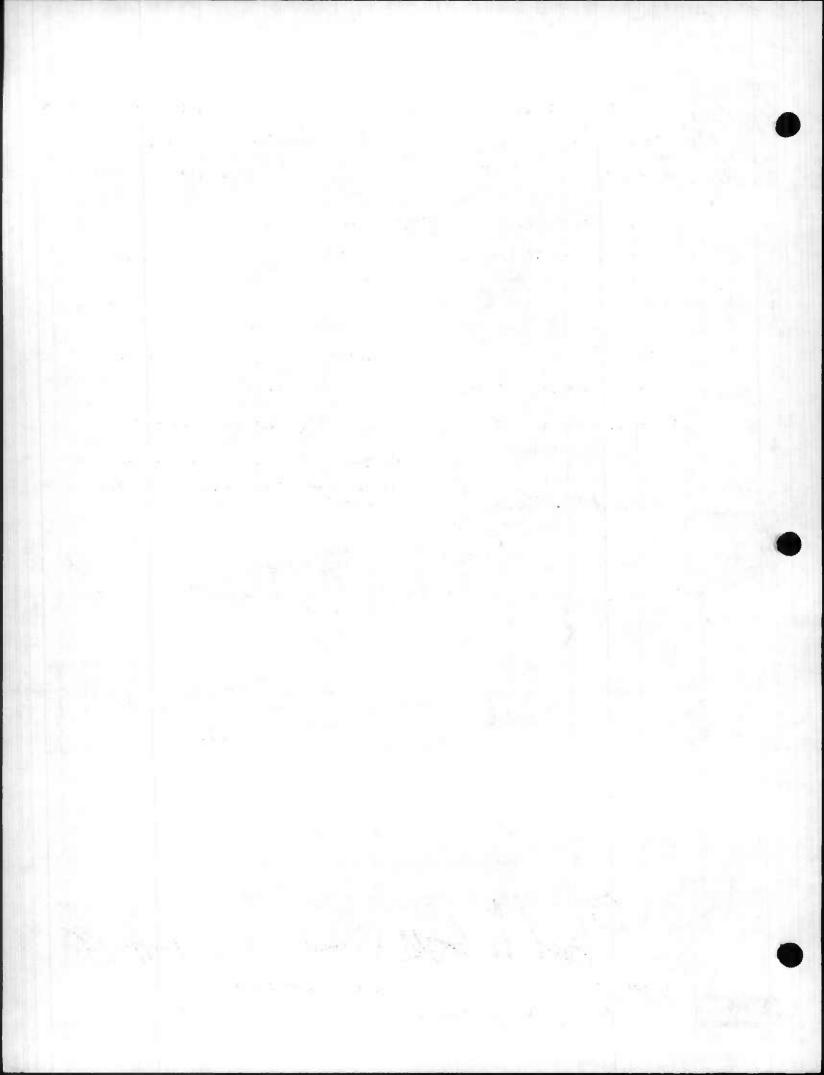
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partment of Health and		

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tor oto	Maryland St. Mar	y's	Mechanic	sville					1 ☐ Yes 2X No
23a or 28a-f s at be notified al Director	10e. Street end Number 39971 Miles Dotso	n Lane		10f. Zip Code 20659			10g. Citizen of V U.S.A		y?
'natural, or tems 23s or 28s-1 show sdical Examiner must be notified at leted by Funeral Director	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	lf Y	s Decedent of les, specify Cub	Hispenic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		a - Americer k, White, et : Whi	c.
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BeC	17. Father's Name (First, Middle, Las	•	Deda	5110	18. Mother's Nam				,01
To	Carl Be	enedict	Copsey,		Janice		Lee		nton
traum	19a. Informent's Name/Reletionship Carl Benedict Cor				tend Number or Ru 2, Mechar			Stete, Zip 0 20659	Code)
Important: If Item 27 eny Injury or other t pncs.	20e. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Speci 21. Signature of Funerel Service Lice 23e. Part1/Enter the disease, or conshook, or heart failure. List only	Removel from State (ty) Audine	Mat P.O	ory or other ple morial ame end Addr tingley . Box 2	Gardens (Coss of Fecility Gardiner 170, Leona	Funera	l Home, Maryla	P.A.	MD 20650
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atached for usa as Physician/Me	Pert II. Other significant conditions	contributing to death but not	resulting In the unde	erlying cause g	ven in Pert I.	23b. Did	tobacco use cor	ntribute to t	the cause of death?
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	30. Neme end eddress of person who				Baltimore,	Maryla	and 2120	1	
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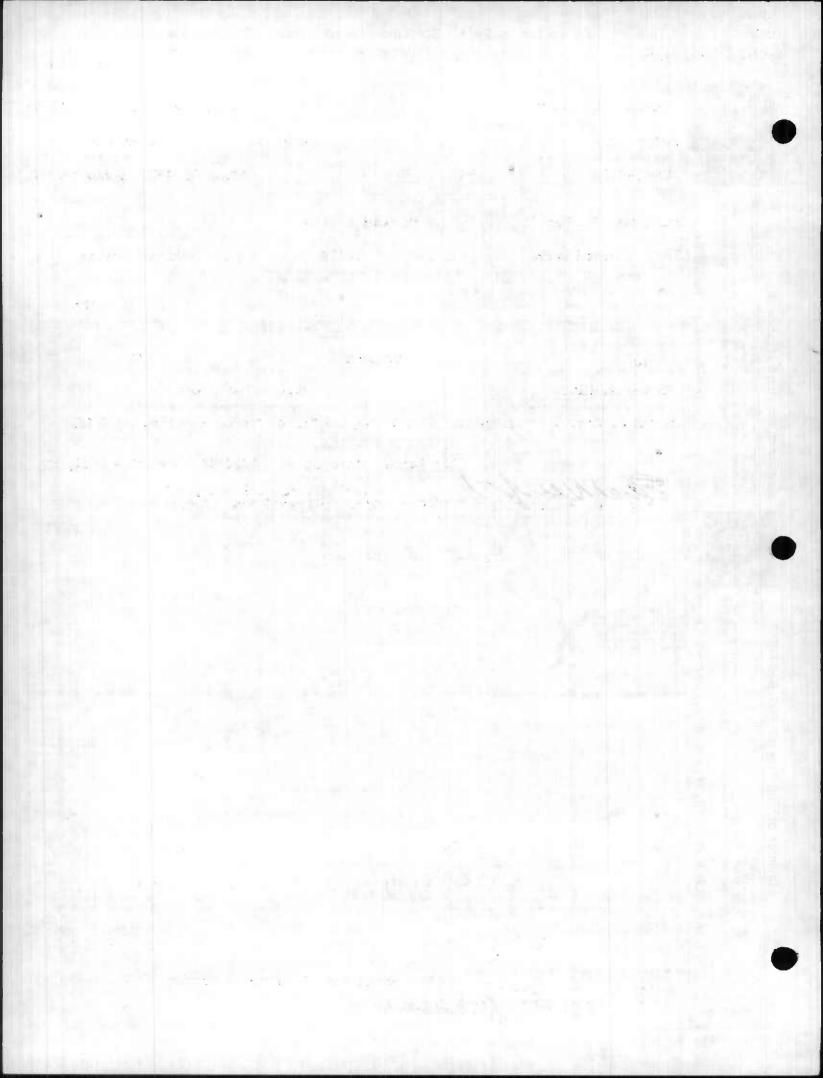
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Examin	_	4e. Fecility Neme (If not institution	on, give str	eet end nun	nber)				4b. City, Town,	or Location o	Deeth	4c. County	y of Deeth	
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Funeral Director		5. Social Security N 214-68-9 Usual Residence of	230	6. Sex		7. Age (In yr. 79	s. lest birthday, Yrs.	Months	r 1 Year Days		Ain. B. Dete (Mon Dec.	of Birth th, Day, 6,]	Year) 1918		place (Stete or Fore ntry) y land
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or items	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☑ Widowed		rried	. Was Dece Armed For 1 Yes If Yes, Give Year or Da	9				Hispenic Origin' an, Mexican, P Specify:	? (Specify Yes uerto Rican, e	or No-		ck, White,	can Indien, etc. hite
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200	To B	Arthur	Vi	ncent	E	vans				Vic	let		Bow1	es	
		19e. Informant's N	ame/Reletions	ship (Type,	, Print)		19b. Maii	ing Address	s (Street	end Number o		Number,	City or Town	, State, Zip	Code)
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AMANDA BETH CLARK

State of Maryland / Department of Health and Mental Hygiene 3 02681

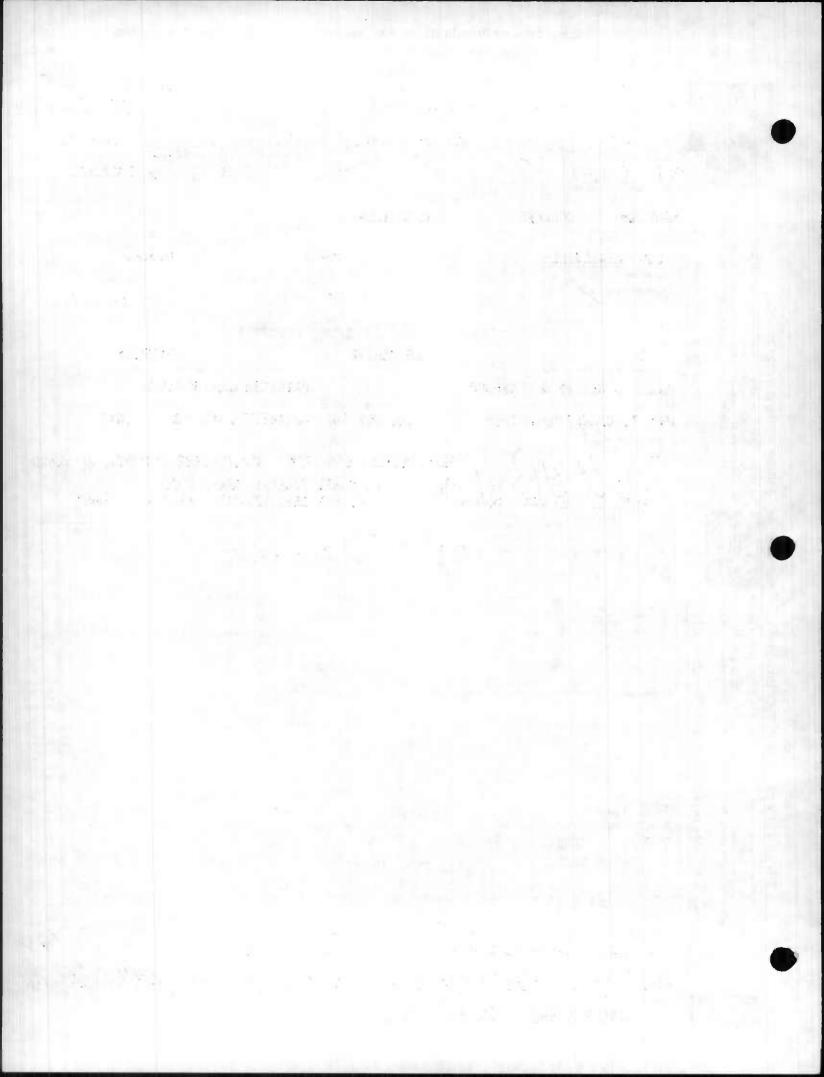
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	1. Decedent's Name (First, Middle, Las	st)					2. Date Mont		Dey	Year	3. Time of Death
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/Medical Examiner	4a Facility Neme (If not institution, give	e street end number)				4b. City, Town,	or Location of	Death	4c. County	of Deeth	
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F S F O	9	9 61			0.0	C.M.E			JAN.	18,	1998
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- 3 - 0	30. Name and address of person who	completed cause of death	Item 23e) (1	ype, Print)							
F \$ F 0	30. Name and address of person who	completed cause of death	Item 23e) (1 111 F	ype, Print) Penn St	reet	, Balti	more, N	lary	land 2	1201	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death JANUARY 1. Decedant's Nama (First, Middla, Last) Day **Physician** 10:29 Am rau Duraine /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner HUnder 1 Year Under 24 Hrs. 8. Date of Birth MARCH (Months, Day, Year) Kuno all stown nesis altimore derca 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 5. Social Security Number **Funeral** 217-68-7198 100M 20 F Yrs. MARYLAND Director Usual Residence of Decadent with the Maryland 10a Stata 10h. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itema 23a or 28a-f ahow traumatic event, it a Modical Examiner must be northled at CHARLES 1 ☐ Yes 2 No MARYLAND **BRYANTOWN** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20617 5650 LEWISVILLE Papes 1 and 2 should be filed within 72 hours effer death neart of Health end Mental Hygiene.

Int. II them 27 is marked other than "natural", or tems 23. Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 12. Was Decedant Evar in U,S. Armad Forces? 11 Marital Status Black, Whita, atc 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Datas: 1 Navar Marriad 2 Married White altimore, Maryland 21215-0020 1 Yas 2DNo Specify à 3 □ Widowed 4 ☑ Divorced Completed 16a. Dacedant's Usual Occupation 16b. Kind of Businass/Industry 15. Decedent's Education (Spacify only highast grade complated) (Give kind of work dona during most of working lifa. DO NOT usa retirad) Elementary/Secondary (0-12) College (1-4or 5+) SECURITY LOCKSMITH 11 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Name (First, Middle, Last) Be LEONARD WINFIELD CRAWFORD PATRICIA JOAN McGOWAN 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) JOHN T. CRAWFORD/BROTHER P.O. BOX 186, BRYANTOWN, MARYLAND 20617 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20s. Method of Di Data Department of Important: If it any injury or o 1 X Burial RESURRECTION CEMETERY JAN.23,1998 CLINTON, MARYLAND 21. Signat THE HUNTT FUNERAL HOME, INC. M00053 P. O. BOX 156, WALDORF, MARYLAND 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** Immediata Causa (Final disaase or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of) Examiner and I-transit the death certificate be executed Sequantially list conditions, if any, laading to immadiata ceusa. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in daath) Last Dua to (or as a consequence of): physicien at s the buriel-t Box 68760 Physician/Medicai Dua to (or as a consaquanca of) 88 use for 23b. Did tobacco use contributa to the cause of death? P.O. by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown 2 The lew requires that Division of Vital Records. by 24b. Wara autopsy findings available prior to should b 24a. Was an autopsy Completed completion of causa of daath? hes i certificate her 1 ☐ Yes 2 Ø No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was cesa rafarred to madical examiner? Be 26. Placa of Death (Check only ona) 1 Yas 2 No Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how Injury occurred 27. Manner of Death 28b. Tima of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Watural 5 Panding 1 Yas 2 No Investigation Director: A 2 Accident 6 Could not be datarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 3 ☐ Suicida Location (Street and Number or Rural Routa Number, City or Town, State) efter 4 | Homicida 24 hours efter Funeral Dire letely filled in b Hospital 29a. Cartifier 1 Certifying Physician: To the best of my knowledga, daath occurrad at the time, date and place, and due to the causa(s) and manner as stated. edical 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. (Check only one) within 2 To the comple 29b. Signature and title of certifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number em 23a) (Type, Print) 32. Registrar's Signatura 31. Data filed (Month, Day, Year) State JAN 2 3 1998 Astri Davidson Revolatt Registrar

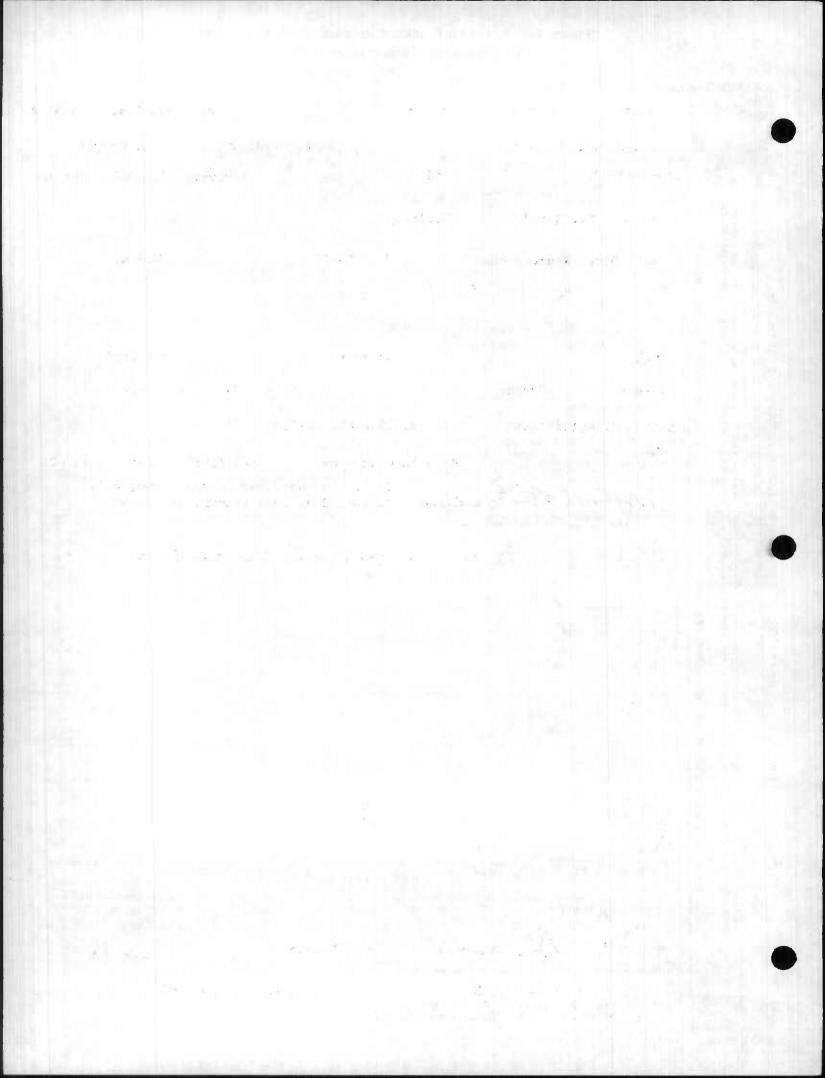
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** January 25, 1998 Helen Blanche Carter 5:55 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, giva straet and number) 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown
If Under 1 Yaar | If Under 24 Hrs. | 8, Dat 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Funeral Deys 1□ M 20XF Min. Yrs. **Director** 214-76-7238 February 17, 1946 Maryland Usual Residence of Decedent with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yas 2 ♥ No Maryland St. Mary's Callaway Directo 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code pemit. Pages 1 end 2 should be filed within 72 hours efter deeth with Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or said fully or other traumatic event, the Medical Experies must be a page. U.S.A. 44875 Buck Redmond Road Funeral 20620 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Datas: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4th Homemaker Own Home 17. Fethar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Be Carter Christine Greenwell Herman Mary 19e. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 66, Callaway, MD 20620 Lottie M. Willis/Aunt 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cramation 3 Ramoval from Stete 4 ☐ Donation 5 ☐ Other (Specify) Holy Face Cemetery 1/31/1998 Great Mills, MD 22. Nama and Addrass of Fecility . Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licenses around P.O.Box 270, Leonardtown, MD 20650 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Probable Myocardine ENFARETION Immediata Cause (Final disease or condition resulting in deeth) /Medical 5-0 Examiner Physician/Medical Examiner The law requires that the death certificate be executed physician end s the burial-trens Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): 98 esn signed by the a Part II. Other algnificant conditions contributing to death but not resulting In the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? been si 24e. Wes en eutopsy parformed? Completed certificate hes b 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Wes case referred to medical exeminer? funeral director, 26. Plece of Deeth (Check only one) Be Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No DOA DOA Certification: To After this 27. Martiner of Deeth 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Naturel 2 Accident 5 Pending investigation s efter deeth. ii Director: Aff 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 1. Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner as steted.

2. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death accounted to the ceuse(s) end menner as steted. edical 29a. Certifier To the Hosp within 24 hos To the Fune completely fi Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and mennar stated. (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifier dimi D14285 1-14-98 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) William D. Boyd II, MD Leonardtown, MD 20650 32. Registrer's Signature State Registrar

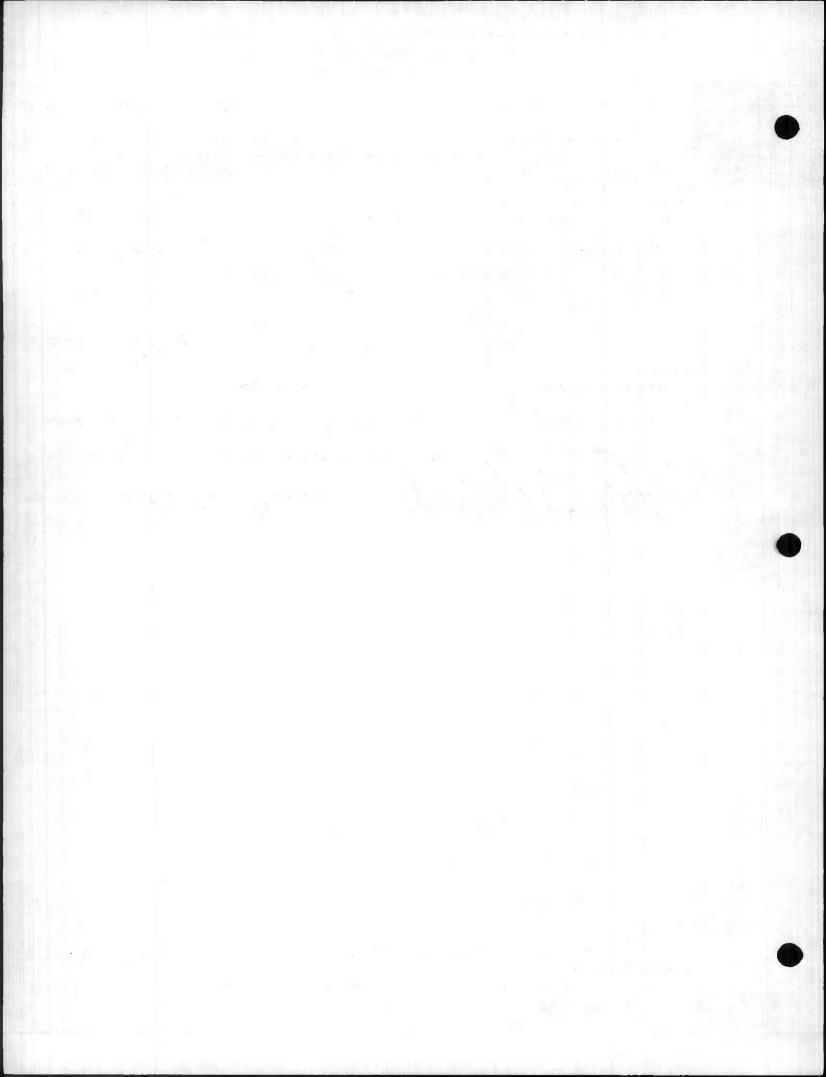
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State of Maryland / Department of Health and Mental Hygiene Q 02601.

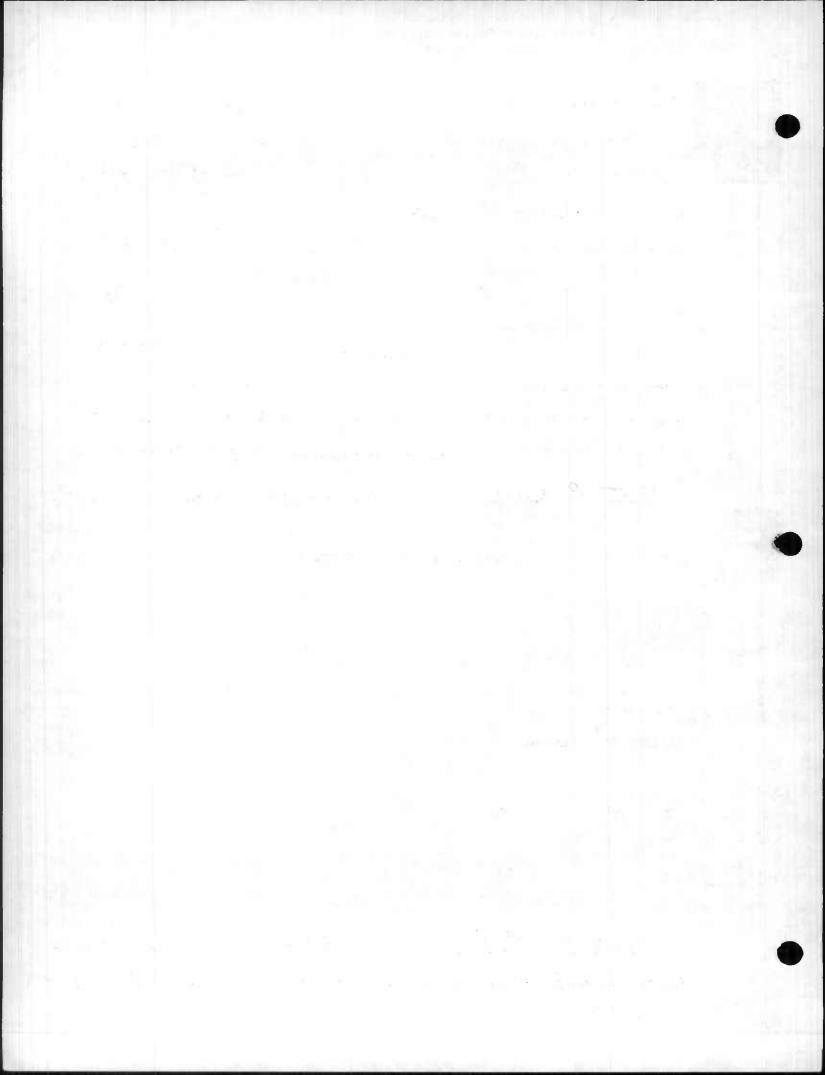
					Certific	cate of	Death		Reg. No.	Ud	2004
Physic /Med		1. Decedent's Name (First, Middle, La Helen George	st) Daumit					2. Date of De Month Janua:	eath Day	9 ^Y 88	3. Time of Death 12:00 PM
Exam	iner	4a. Fecility Name (If not institution, given 1917 Queensguar	d Road				Silv	or Location of Deat	g Mc	ntgom	-
Funera Directo			7. Age (In 80	yrs. lest birt	Yrs.	nder 1 Yea ths Deys		in. 8. Dete of Bi	th (Year) 1917	9. Birthp Coup	lece (Stete or Foreign (17) Vash., DC
Ba-f show	ector	MD 10b. County MD Montgo			or Location	pring				16	0d. Inside City Limits XX Yes 2□ No
th with the 23a or 2	Funeral Director	1917 Queensguar	d Road		101	. Zip Code 2	0906		10g. Citizen of Unite	What Coun d Sta	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Expirence must be notified an any once.	b	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give X Year or Dates:	in U,S.		ecedent of specify Cu es XX No		(Specify Yes or No erto Ricen, etc.)	- 14. Ra Bla Specia	ce - America ck, White, o by: W	
d 2 should be filed within 72 hours af the and Mental Hyglene. 7 is marked other than "natural", or traumetic event, the Modical Exam	Completed	15. Decedent's E (Specify only highest gra	ducetion ade completed)	16a.	Decedant's (Give kind o	Usual Occu	upation e during most of v ed)	working	16b. Kind of B		
d withi	Сошр	Elamantary/Secondary (0-12)	College (1-4or 5+)		Office					e Con	struction
uld be file Mental Hy rked oth	To Be (17. Father's Name (First, Middle, Last George J. Georg						Name (First, Middle Shama			
and 2 sho laith and 1 27 is me	ľ	19a. Informant's Name/Relationship (David George Da						Rural Route Numb			
Pages 1 nent of He ant: if item ury or oth		20a. Method of Disposition 17 Burial 2 Premation 3 4 Donation 5 Other (Special	Themoval Ironi State	Place of cometar, Ft.	Disposition y, crematory Linco	(Name of or other pl Ln Cer	ece) metery	Date 1/17/98	20c. Location Brentw		
permit. Pages 1 el Depertment of Hea Important: if Itam; any injury or othe once.		21. Signature of Funeral Service Lice	1.4000	and	1/		ress of Facility aldi Fun	eral_Home	11800	New_	Hampshire
Physician		Shock, or heart failure. List only	plications that caused the cone cause on each line.	death. Do n	ot anter the	mode of dy	ring, such as cero	AVE SILVE	er Sprin	ig, MD	Approximata Intarval Between Onset and Death
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. MYOCARDI		FARCTI						5 "
ed sit	Examiner		b. CORONARY								5_''
law requires that the death certificate be executed as been signed by the ettending physician end 2 should be deteched for use as the buriel-transit	Medical	Sequentially list conditions if any, leading to immediate ceusa. Enter Underlying Cause (Diseasa or Injury that initieted events resulting in death) Last	c. CORONARY	ATHE	consequence ROSCER consequence	OTIC	DISEASE			I	ndefinite
ne deeth cert the ettending	Physician/	Part II. Other eignificant conditions of		resulting In	the underlyi	ng ceuse g	iven in Part I.	23b. Did	tobacco use co	entribute to	the ceuse of death?
res thet the de igned by the be deteched	by Ph	Hypertension						- 10	Yes 2 No	3 Prob	bably 4 🗆 Unknown
ne law requires the law secures to hes been signed to a should be considered.	Completed t	Hypercolesterol	emia						an autopsy ormed?	cor	pre eutopsy findings allabla prior to mpletion of ceuse death?
The ate h	Com	Diabetes Melli	tus					10	Yes 2No	1 🗆	Yes 2□ No
Physician: The this certificate	o Be	25. Was case referred to medical exeminer? 1 Yes 2 No	Hospital:			0	thor	Deeth (Check only		40 11	
Phy ral o	ation: To	27. Manner of Death 1XXNatural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea			28c. Inju	4 🗆 IVUISIII	g Home 5 X Resi	how Injury occur		9
al or Attending s after death. Il Director: After ed in by the fune	Certification:	3 Sulcide 6 Could not be determined	28e. Place of Injury - / building, atc. (Sp	At home, far ecify)	m, street, fa	ctory, office		28f. Location (City or To	Street end Numi wn, State)	ber or Rura	l Route Number,
To the Hospital or Atterwithin 24 hours after de To the Funeral Direct completely filled in by the	edical C	29a. Cartifiar (Check only one) 1 X Certifying Ph. 2 Medical Example 1	yalclen: To the best of my niner: On the basis of exan and menner stated.	knowledge, nination and	daath occur Vor invastiga	red at the tition, in my	time, date and pla opinion, death or	ace, end due to the courred at the time,	ceuse(s) and m date and place,	annar as stand due to	ated. tha ceuse(s)
To the within 2 To the comple	Me	29b. Signeture and interest of certifier	r 24		1.	29c. Licer	ise number		29d. Date signe	ed (Month, L	Dey, Year)
V		30. Nama and address of person who	complated cause of death (, ,		D09			Januar		
St	ate	Lawrence D. Marci	A State of S	313 Ge	orgia	Aven	ue, #207	, Silver	Spring	, Mary	land 20902
Regist	rar	JHM 20 193	O demonstration		.,						

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State of Maryland / Department of Health and Mental Hygiene 98

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/Medical	1				. 4		-					January			998	11:	07am
Examiner	r	4a. Facility Nama (If not institute Shady Grove A							4	Rock		cation of Death	-		of Death		
Constituti	4	5. Social Sacurity Number	6. 9		Age (in yr:		(day)	If Unde	r 1 Yaar	If Under 2				Onc	gomer		n na Franci
Funeral Director		092-07-5184 Usual Residance of Dacedent		□M 2ሺF	91			Months		Hours	Min.	8. Data of Bird (Month, Da Feb. 1		06	9. Birthplac Country New	Yor	k
Mot W		10a. Stata 10b. Cour				City, Town									10d	. Insida	City Limit
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at be not	al Direc	10e. Street and Numbar 201 Russell A	ve.					10f. Zip	Code 208	77					That Country State		
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aalth and n 27 Is m ier traum		19a. Informant's Name/Ralatio Joan M. Panno		Type, Print) Daughter)								1Routa Numbe 9 Wacca					
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State		31. Dete filed (Month, Day, Yea	100	32. Ragi	strar's Sign	ature				,				,			



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey 1998 Month **Physician** MOSHE DWECK Jan. 18, 6:00 pm /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Suburban Hospital Bethesda Montgomery If Under 1 Yeer Months Deys Hours Min. June 7, 1923 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country)
Syria **Funeral** 1 M 2□ F 092-42-1900 74 Yrs. Director Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Directo New York Kings Brooklyn 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? filed within 72 hours efter death with Examiner must be 2111 Avenue M 11210 USA Funeral 12. Was Decedent Ever In U.S. Armed Forces? 13. Wes Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Maryland 21215-0020 "natural", or white 1 Yes 2 No ill. Peges 1 end 2 should be filed witten indicate and 2 should be filed witten indicate at a state of the st à Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) import merchant novelties/merchendise 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Yaacov Dweck Jamileh unknown 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Naomi Dweck (Wife) 2111 Avenue M Brooklyn, NY 11210 Baltimore, 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete permit. Pege Department of important: If eny injury or Hebrew United Cemetery 1/18/1998 4 ☐ Donation 5 ☐ Other (Specify) Staten Is., NY 21. Signature of Foheral Servica Licensee 22. Neme end Address of Fecility Danzanski-Goldberg Memorial Chapel complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, only one cause on each line.

1170 Rockville Pike Rockville, MD 20852
Approximate Intervel Between Onset and Death Pert1. Enter the disease, of conshock, or heart failure. Lift only **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) meymonia Examiner Due to (or es e consequence of): Completed by Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of) Dacral Decubitus NIMON OI BG and AVE Hoshe Dweek January for use Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Diabater Melletus 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director. 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) 1 Yes 2 No 1 Monpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 1 Netural Medical Certification: 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Yes 2 No 2 ☐ Accident filled in by the Director 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyelclen: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29e. Certifier (Check only one) To the Vithin 2 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Old Georgetown Road, Betherda MD 20814 8600 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State July Davidson JAN 20 1998

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Martha Campbell January 18, 1998 Dodd 12:20 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Chesapeake Health Care Center Arnold Anne Arundel County 8. Date of Birth (Month, Dey, Yeer)
Jan. 28, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Hours 1 M 2 XF 227-36-9651 80 Yrs. Director 1917 Virginia Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Modical Examiner must be notified at XXYes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1728 Cedar Park Road 21401 United States of America Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 □ Divorced Specify: White "natural", Completed 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nat any injury or other traumatic event, the Wellan once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Line Worker -2-Morton Frozen Foods 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Harvey Campbell Alice Campbell 19a. Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Martha Ann Thorn - Daughter 1728 Cedar Park Rd. Annapolis, MD 21401 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State January Beech Grove Cemetery 22, 1998 Roseland, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Facility #M00690 Byrum-Parr Funeral Home wordhlassen P.O. Box 10, Roseland, Virginia 22967 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert teilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medicai Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner uldier Examiner that the death certificete be executed physician end the buriel-tran Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Last Box 68760 Physician/Medical Due to (or as e consequence of): Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? robety Mellelus 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown s been signed to should be det Records. þ 24b. Were autopsy tindings aveileble prior to Completed 24e. Wes en autopsy completion of cause of deeth? pege 2 director, ped 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifics stely filled in by the funeral director, i Be 25. Wes cese reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as stated.

2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature end title of certitier 29c. License number 29d. Date signed (Month, Dey, Year) Whymae M Attenday Doctor D21684 1-21-98 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CN, CYR IAC-M-D SIOS RITCHIR UNIT PASADRNA MO 21122

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JAN 23 1998

32. Registrer's Signeture

hia Davidson-Randalle

Heroresplaner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #8, Per F.D. 1/21/98, Carroll County, wil Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Date of Death **Physician** David Lee Duke /Medical 4b. City. Town, or Location of Deeth 4c County of Deeth 4a. Fecility Name (If not institution, give street end number) Examiner 5311 Overhill Road Woodlawn Baltimore 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** 15 M 20 F Months Deys Hours 66 Yrs. Director 215-28-6642 Aug 9 Maryland Usuel Rasidence of Decedent Aug. 6, 1931 the Maryland 10e. Stete 10b County 10c. City, Town or Location is 23a or 28a-f show 10d. Inside City Limits Director MD Baltimore Woodlawn 1 ☐ Yes 2 TXNo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5311 Overhill Road 21207 United States Funeral death items : 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bteck, White, etc. the Medical Examiner filed within 72 hours after 1 Never Married 2 ☐ Merried 21215-0020 6 1 ☐ Yes 2 ☐ No Specify by Specify: 3 ☐ Widowed 4 ☐ Divorced white "natural", Completed 16a. Dacedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiena. Elamantary/Secondary (0-12) Cotlega (1-4or 5+) Pages 1 end 2 should be filed w tment of Health end Mental Hygier tant: if Item 27 is marked other th jury or other traumatic event, letter carrier Post Office Baltimore, Maryland 17. Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Malden Sumame) Francis Pretlow Duke Nora Ardelia Barlow 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Coda) Aveney Sca 20a. Method of Disposition Schenevus SCOTTO SISTER WILLAMS 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1/16/98 1 ☐ Buriel 2 【** Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Depertment of Important: If any injury or Carroll Cremations, Inc. Hampstead, MD 21. Signeture of Funeral Sanda Liou 22. Neme end Address of Facility Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD emplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finet disease or condition rasulting in deeth) **Examiner** lexolic Due to (or as a consequence of) The law requires that the daath certificate be executed Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Cause (Disease or injury that Initiated events resulting in daeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of) Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably TUnknown signed by by Pe Completed 24e. Wes en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? paga 2 2 NO Aftar this certificate 1 Yes 1 ☐ Yes 2 ☐ No or Attanding Physician: director, 25. Wes case referred to medicat Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1 Xas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA filled in by tha funeral 27. Manney of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 28b. Time of 1 Maturel death. s efter death

P.O. Box 68760, Records, of Vital Division

5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, fectory, office building, etc. (Spacify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicida 29a. Certifier 1 Certifying Phyelcien: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred et tha tima, data end place, end due to the ceuse(s) and manner statad. Medical (Check only one) 29b. Signature and little of certifier -29c: License number 29d. Date signed (Month, Dey, Yeer)

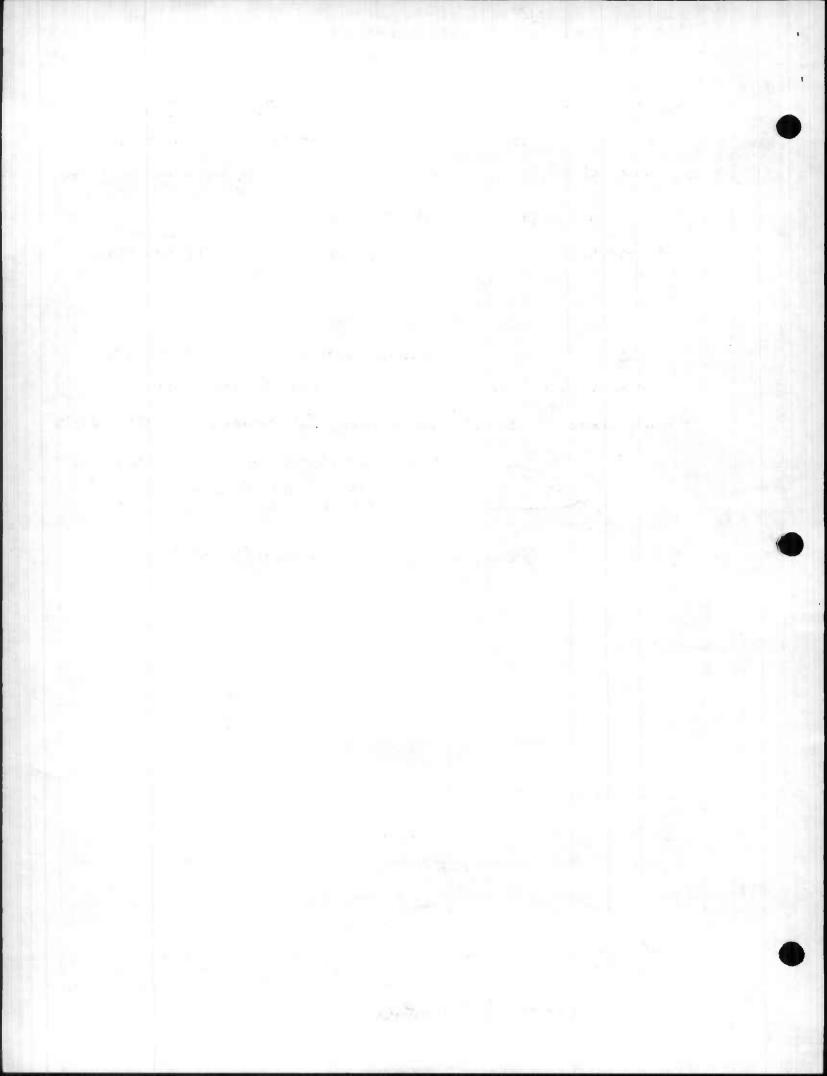
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30. Name and addrass of person who 122 31. Dete filed (Month, Dey, Yeer)

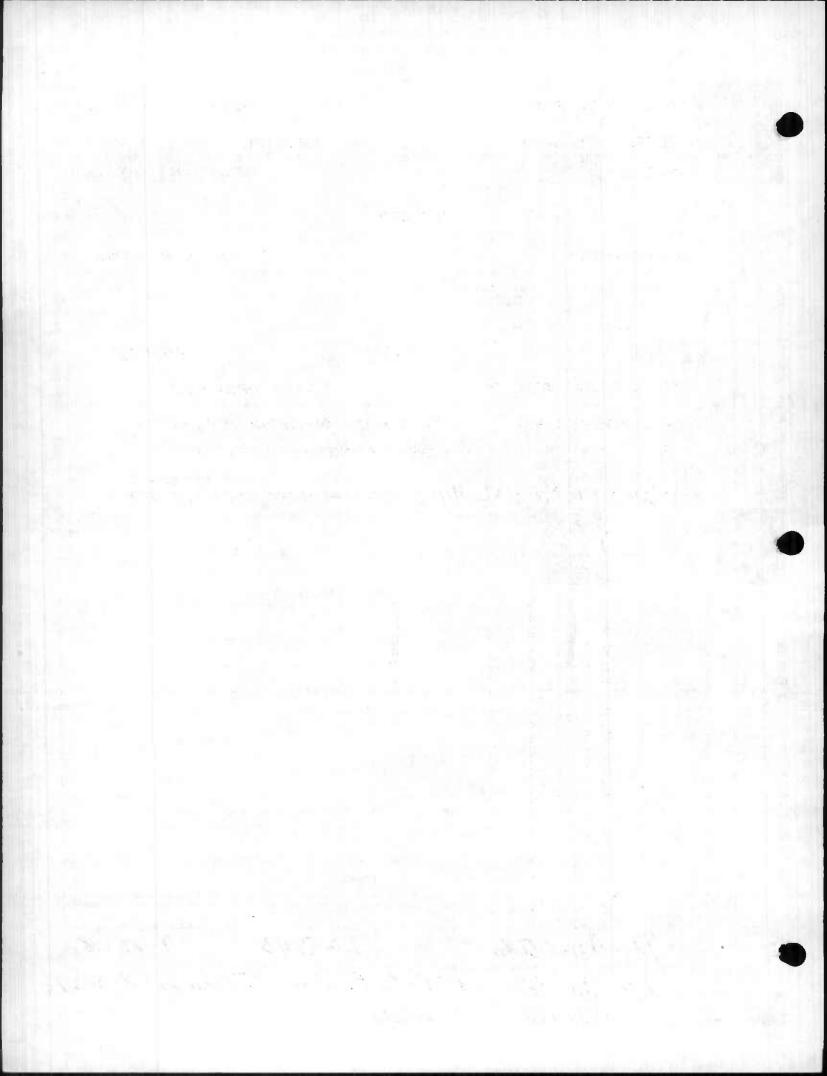
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To the Hospital within 24 hours e To the Funeral C Hospital



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Daath **Physician** LESTER ELY DRECHSLER JANUARY 1998 16 5:20 a.m. /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WESTMINSTER NURSING HOME WESTMINSTER CARROLL 5. Social Sacurity Number If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) OCT 23, 1914 Birthplaca (Stata or Foraign Country)
 MARYLAND 7. Aga (In yrs. last birthday) **Funeral** MDM 2□F Days Hours 83 Yrs. Director 212-48-6837 Usuai Rasidance of Dacedant death with the Maryland 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits ms 23a or 28a-f show CARROLL WESTMINSTER Director 1 ☐ Yas 2 No 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? 1640 BALTIMORE BLVD. 21157 UNITED STATES 12. Was Dacedant Evar In U,S. Armad Forcas? 1 ☐ Yas ② No If Yas, Giva Yaar or Datas: items. Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian Black, Whita, atc. r than "natural", or iten Pages 1 and 2 should be filed within 72 hours after mant of Health and Mental Hygiena.
ant: If item 27 is merked other than "natural; or ite ury or other traumatic event, the Mexical Examina 1X Navar Married 2 ☐ Marriad 21215-0020 1 Yas 2 No WHITE Specify: Completed by 3 ☐ Widowad 4 ☐ Divorced 16a. Decadant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) FARMER 10 DAIRY AND BEEF Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maldan Sumama) Be GEORGE WILLIAM DRECHSLER LAURA BURNETTE ELY 19a. informant's Nama/Ralationship (Typa, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) permit. Pages 1 end 2. Department of Health er Important: If Itam 27 is any injury or other trae EVELYN THOMPSON/SISTER 14013 NOTLEY ROAD, SILVER SPRING, MD 20904 Baltimore, 20b. Placa of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata EVERGREEN MEM GARDENS 1 ⊠ Burial 2 □ Cramation 3 □ Ramoval from State 1/19/98 FINKSBURG, MD 4 ☐ Donation 5 ☐ Othar (Spacify) Signatura of Funaral Service Licen 22. Nama and Addrass of Facility 91 WILLIS STREET MYERS FUNERAL HOME WESTMINSTER, MD 21157 23a. Part1. Entar tha disaasa, or complications that caused the dearn. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Physician /Medical Immediata Causa (Final Melastatic Concer- Basal Cell disaasa or condition rasulting in death) Examiner Examiner The lew requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseese or injury that initiated avents rasulting in death) Last pue Dua to (or as a consaquance of): buriel-tran Division of Vital Records, P.O. Box 68760, ed by the attanding physician detached for use as the burie Physician/Medical Dua to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown à page 2 should be Completed 24b. Wara autopsy findings available prior to 24a, Was an autopsy peen complation of causa of death? certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No Attending Physician: Be 25. Was casa rafarred to medical axaminar? 26. Piaca of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatiant 3 DOA this funeral 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred After s effer dea....al Director: Affer 5 Panding Investigation Neturai 1 Yas 2 🗆 No 2 Accident 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 5 To the Hospital within 24 hours e To the Funeral C 1 Cartifying Physician: To tha bast of my knowledga, death occurred et the time, deta and plece, end due to the causa(s) and mannar as steted.
2 Medical Examinar: On tha basis of axamination and/or investigation, in my opinion, death occurred et tha tima, date and place, end due to tha causa(s) and mannar statad. 29a. Cartifier Medical (Check only one) 29b. Signature and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Yaar) and eddress of person who complated ceuse of death (Itam 23a) (Type, Print) Road Westminder, Ind 2113 31. Data fied (Month, Day, 32. Registrar's Signatura State Registrar



Please Type or Print in Black indeiible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Deeth 3. Time of Death Month Dev Vee **Physician** Sarah Verona Dumont 16, 1998 3:35 PM January /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Undar 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys 1 M 2 F Months Director 233-68-9436 March 23, 1916 West Virginia Usuel Residence of Deceden 10c. City. Town or Location 10d. Inside City Limits 10e. Steta 10b. County "natural", or items 23a or 28a-f ahow exical Examiner must be notified at 1 ☐ Yes 2 ■ No Maryland Directo St. Mary's Mechanicsville 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 27161 Three Notch Road 20659 Funerai United States 14. Rece - American Indien, Black, Whita, atc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status e filed within 72 hours efter de al Hygiene. other then "neturel", or frem 1 ☐ Yes 2 ■ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ■ No Specify: Specify P 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker N/A 17. Fathar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) . Peges 1 end 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth jury or other traumatic even Be Charles Griffin Helen Wertz 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Georganna Marguess 27161 Three Notch ROad, Mechanicsville, MD 20659 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ■ Buriel 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) 1/20/98 Mechanicsville, MD Zion U.M. Cemetery 21. Si aral Sasta Li 22. Name end Address of Fecility Brinsfield Funeral Home, P.A. Brinsfield runeral Home, MO0052 22955 Hollywood Road, Leo 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only one cause on each line. 22955 Hollywood Road, Leonardtown, MD 20650 Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or es e consequence of) Examiner Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings 24a. Was en eutopsy performed? Completed completion of cause of deeth? 1 Tyes 2 DN 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other, 4 Housing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how Injury occurred

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or Attending Physician: efter death. Director: / within 24 hours eff To the Funeral Di completely filled in the Hospital

28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Tima of 28c. Injury et Work? Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, sfreet, factory, office building, etc. (Spacify) 4 I Homicide

29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end menner stated. (Check only one) 29d. Date signad (Month, Dey, Year) 29c. Licansa number 29b. Signature and title of certifian

31. Dete filed (Month, Day, Year)

JAN 2 0 1998

David Allen, M.D.

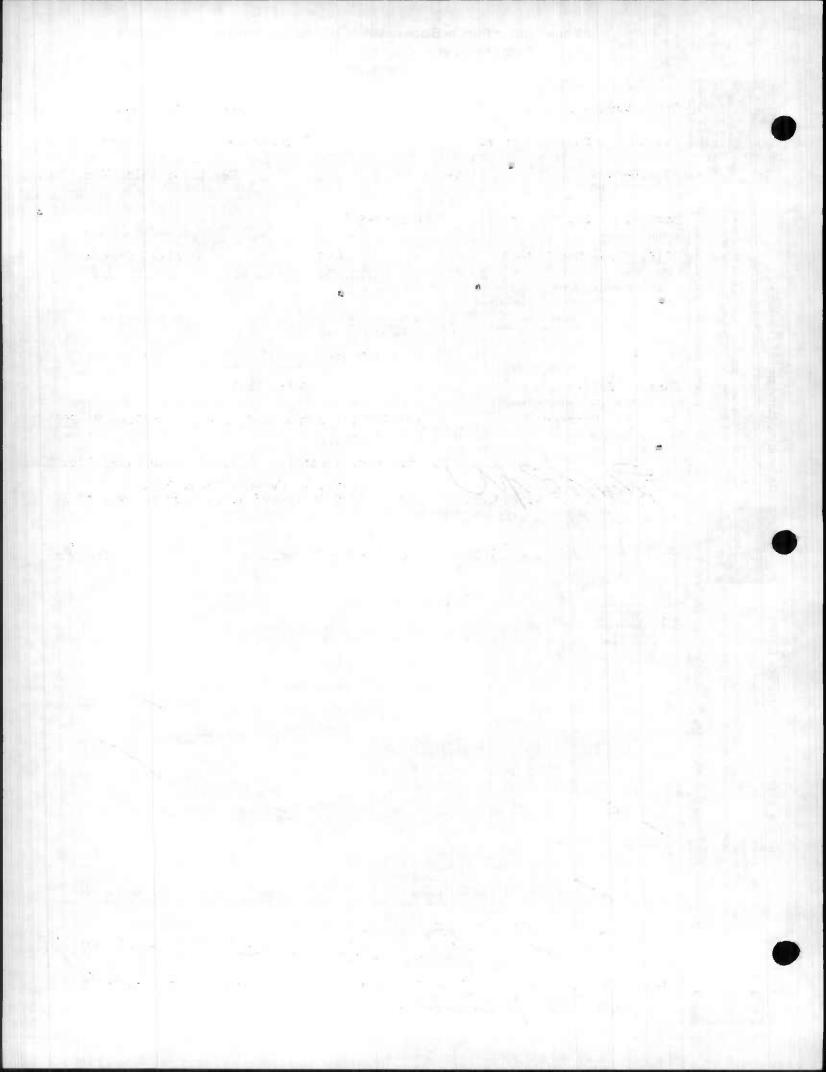
peath (Time 23e) (Type, Print) 30. Neme and eddress of person who completed cause of

2050 Wildewood Court, California, Maryland 20019

State Registra

edical

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1998 January 8:20 PM Mildred Ann Duke /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 ■ F Yrs. Director 88 454-16-7839 September 9, 1909 Maryland Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ■ No Director Leonardtown Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 24400 Pin Cushion ROad 20650 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ■ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: PV Specify 3 ■ Widowed 4 □ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Depertment of Health and Mentai Hygiene. Important: If Item 27 is marked other than "nany Injury or other traumatic account. Elementery/Secondery (0-12) College (1-4or 5+) Jeweler Jewelry Store 8 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be Joseph Mason Lena Somerville 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mildred A. Gross, 40698 Eddie Nelson Road, Leonardtown, MD 20650 Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burlal 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Queen of Peace Cemetery 1/22/98 Helen, Maryland of Fiftheral Service 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Blankenship Michael 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Betwe Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner week Examiner be executed burial-trensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of Box 68760. physiclen Physician/Medical the Due to (or as a consequence of): 8 attending to P.O. ed by the a Part II. Other significant contributing to de but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed to Records. þ 24b. Were autopsy findings available prior to completion of cause leath? pege 2 should Completed 24a. Wes an autopsy performed? has been After this certificate 2ETNO Division of Vital Be 25. Was cese referred to me 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1.EInpatient 1 Yes 2 □ 2 ER/Outpetient 3 DOA 27. Manner 1 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? or Attending 5 Pending Investigation 1 ANatural death. To the Hospital or Attendition within 24 hours after death.

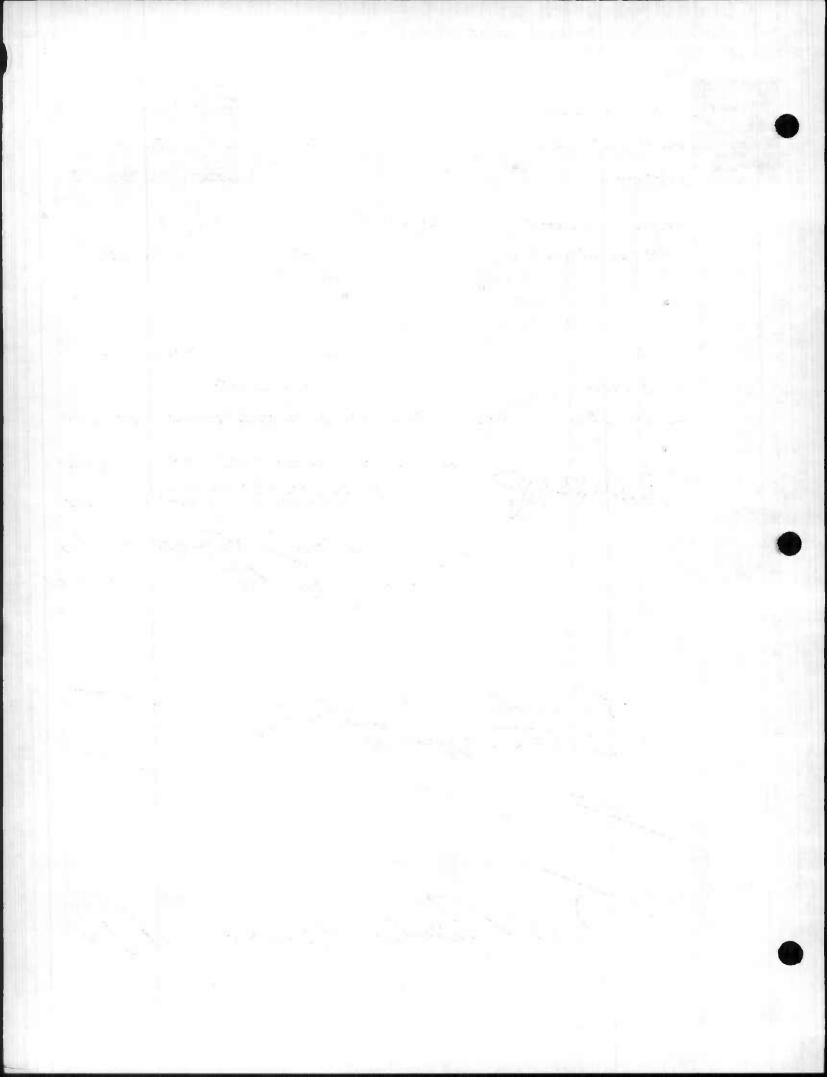
To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Modical Examiner: On the basis of ordinary and manner lated 29a. Certifier Medical mprige, death occurred et the time, date and place, end due to the cause(s) and menner es stated.
In and/or investigation, in my opinion, death occurred at the time, date end place, and give to the cause(s) (Check o 29b. Signature and title of g 29d. Date signed (Monthy Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID M. FEDERLE M.D. PHILIP J. BEAN MEDICAL CTR. HOLLYWOOD, MD. 20636 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

Julia Daviden Rardall

DHMH 16 Rev 6/95

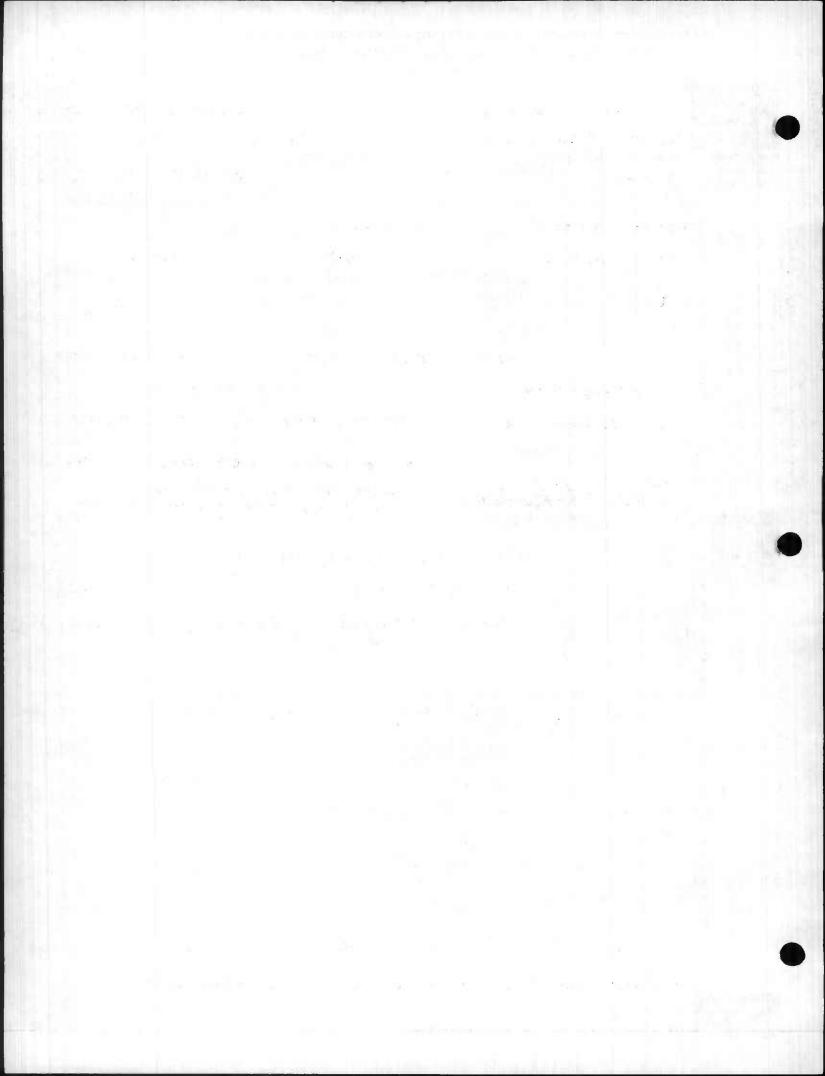
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MILDRED DUKE



State of Maryland / Department of Health and Mental Hygiene

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nar mis carmicate nes been s ineral director, paga 2 should on: To Be Completed		axaminar? 1	28a. Data of I (Month,	Injury - At he, atc. (Spacifiest of my knos of axamina	28b. Tima of Injury	eat, factory	8c. Injur Wor 1 , offica	ar: 4□ Nursin y at k? Yas 2□ No	perfi	Yas 2 (A) ona) danca 6 [how injury c Street and N wn_Stata)	Other (Special Course) Other or Run Id manner as s	railabla prior to mmplation of causa deeth? Yas 2 No No No Ry)
ineral director, paga 2 should		axaminar? 1	28a. Data of I (Month, on De 28a. Place of building, hyalclan: To the beminer: On the bask	Injury - At he, atc. (Spacifiest of my knos of axamina	28b. Tima of Injury	eat, factory occurred a restigetion,	8c. injur Wor 1 - , offica	ar: 4□ Nursin y at k? Yas 2□ No	perfi	Yas 2 Stoona) danca 6 E how injury c Street and N causa(s) and	Other (Special Course) Other or Run Id manner as s	railabla prior to morplation of causa deeth? Yas 2 \sum No No No Ry)
ftar this cartificate hes been s ineral director, paga 2 should on: To Be Completed		axaminar? 1	28a. Data of I (Month, on 28a. Place of building, hyalclan: To the basi and mannar	Injury - At hatc. (Spacifiest of my knos of axamina stated.	28b. Tima of Injury	occurred a restigation,	8c. injur Wor 1 - , offica	ar: 4 Nursin y at k? Yas 2 No ma, data and ple plinion, deeth of	perfi	Yas 2 Stoona) danca 6 E how injury c Street and N causa(s) and	Other (Special Course) Other of Run Indiananar as sece, and due to	railabla prior to morplation of causa deeth? Yas 2 \sum No No No Ry)
• Funeral Director: After this cartificate hes been s plately filled in by the funeral director, paga 2 should edical Certification: To Be Completed		axaminar? 1	28a. Data of (Month, on 28a. Place of building, on 28a. Place of building, on the bask and mannar a	Injury Day Year) Injury - At he atc. (Spacification of axamina stated.	28b. Tima of Injury oma, farm, struy wledga, daath tion and/or Inv	occurred a estigetion, 29c D-Print)	8c. Injur Wor 1 - , offica at tha tir in my o	ar: 4 Nursin y at k? Yas 2 No na, data and pli plnion, deeth of a numbar	Daath (Check only g Homa 5 Ras 28d. Dascribe 28f. Location City or To	Yas 2 (Street and Nown State) causa(s) and date and pl	Other (Special Course) Other (Special Course) Odd manner as sece, and due to bigned (Month,	railable prior to morplation of causa deeth? Yas 2 No No No No No No No No No No



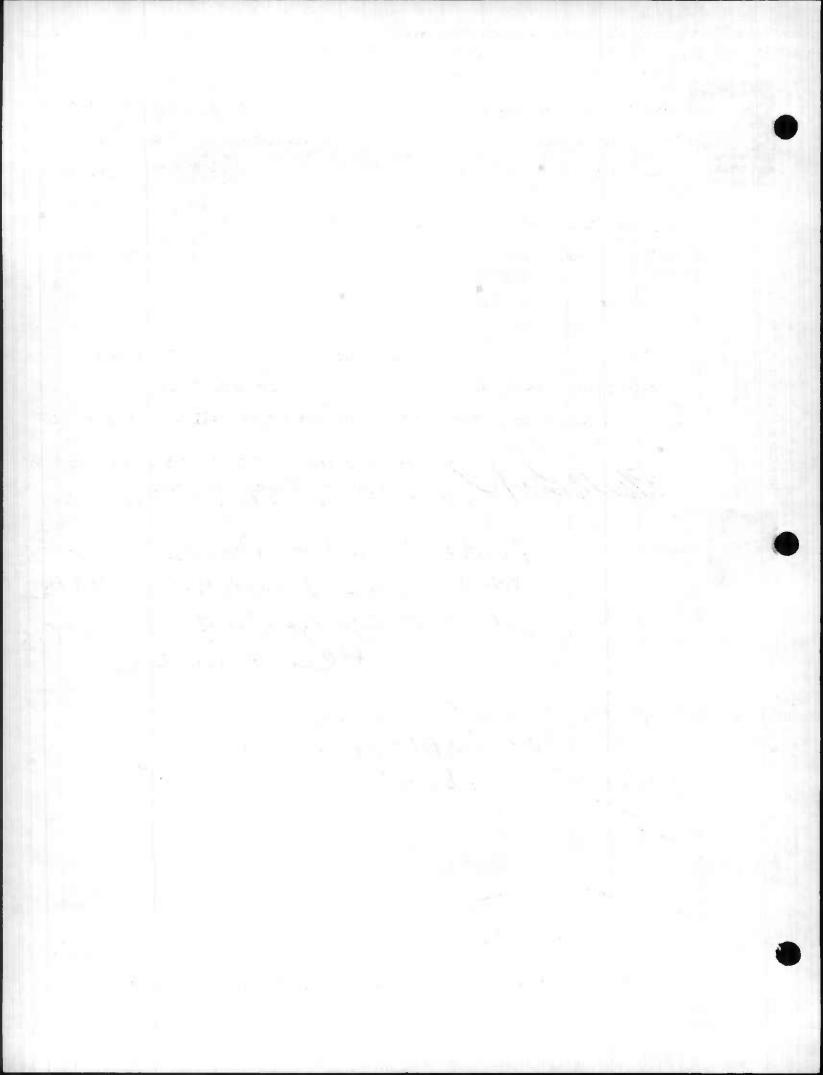
State of Maryland / Department of Health and Mental Hygiene

02593

					Cei	tificate of	Death		Reg. No.		0 2 0 3 3
н	72		1. Decedent's Nema (First, Middle, Last)				2. Dete of De	_	Veen	3. Time of Death
	Physic		Kenneth Russell De	ement. Jr.				January	y 27 1	1998	4:30 AM
	/Medi Exami		4a. Facility Name (If not institution, give				4b. City, Town, o	Location of Death	4c. County	of Deeth	
	-Autili		St. Mary's Hospita	al			Leonard	ltown	St.	Mar	v's
1	Funeral		5. Sociel Security Number 6. Se		rs. last birthday)	If Under 1 Yae					pleca (State or Foreign
L	Director		220-66-8111 Usuel Residence of Decedant	M 2□ F 42	Yrs.	Months Days	s Hours Mir	August 2	8, 1955	Ma	ryland
	anyland show		10a. Stete 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	the Mar 28a-f st notified	tor	Maryland St. Mai	v's C	allaway						1 ☐ Yas 2 ■ No
	or 28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	Whet Cou	ntry?
	death with the Maryland ms 23a or 28a-f show		20721 Piney Point	Road		20620			Uni	ted	States
5-0020	or its	by Funeral	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Evar in Armed Forces? 1 ☐ Yas 2 ■ No If Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cu 1 ☐ Yas 2 ■ No	Hispenic Origin? (ben, Mexican, Pue	Specify Yas or No rto Rican, atc.)		ck, White,	can Indian, , atc.
2-0	"natural",	Be Completed	15. Decedent's Edu	cation	16a, Deced	lent's Usuel Occu	upation e during most of w	netine	16b. Kind of B	usiness/in	ndustry
2121	within 7 ene. than "r	ple	(Specify only highest grad	Collaga (1-4or 5+)	life. I	DO NOT use retir	e during most of wi ed)	orking			
21	77 5 1	Con	12		Car	penter			Const	ruct	ion
pu	be filed tal Hygi d other	Be	17. Fether's Neme (First, Middle, Last)				18. Mothar's Na	ame (First, Middle,	Maidan Suman	ne)	
yla	should b nd Menta markad imatic e	2	Kenneth Russell De	ement, Sr.			Shirley	Marie C	Cusic		
Maryland	end is m		19e. Informent's Name/Relationship (T)				et and Number or F				
	s 1 end 2 should be filed f Health end Mental Hyg tem 27 is markad othe other traumetic event,		Kenneth R. Dement				Point Ro				and 20620
altimore	(i) (i)		20e. Method of Disposition 1 ■ Burial 2 □ Cremetion 3 □ F 4 □ Donetion 5 □ Other (Specify)	tamoval from State		natory or other pl		Dete	20c. Location		own, Stata Maryland
Balti	permit. Page Department of Important: if any injury or		21. Signature of uneral Service License	WIV				cal Home,	P.A.		MD 20650
ı			23a. Part1. Enter the disaase, or complishock, or heart failure. List only or	cetions thet causad tha d	aath. Do not ent	er the moda of dy	ring, such as cardi	ac or raspiratory a	rrest,		Approximeta Intervel Between
	Physician /Medicai Examiner		Immediata Ceusa (Final diseasa or condition rasulting in death)	Acute	2 Re	nal	fa	ilur	e_	1	Onset end Death
L		ner	rasulary in daziliy	Moto	(or es a conseq	juence of):	Aci	dus	10	1	48 Hx
	icete be executed physician end s the buriel-transit	Examiner	Sequentially list conditions,	Due to	o (or es e consaq	uance of):	1		1		/ - //63
0,	e exe lan e uriel-l		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseese or Injury	SEVA	280	(O)1-	008	110			211
68760	ate b	Ilca	thet initiated evants rasulting in death) Last	Dua to	(or es a conseq	uence of):	70		71867	1.	> 720
	certificate be nding physicla use as the bur	Medical		1		++6	20	Ato	10		
Box								III	in	ER.	_
	the etter thed for u	SICI	Pert II. Other algnificent conditions con	tributing to death but not	resulting In the u	nderlying causa g	ivan in Pert I.	23b. Dld 1	tobacco use co	ntribute t	to the cause of death?
, P.O	\$ % ¢	by Physician	SIP HOST	12 2T	Vicu	Shid	f	10	Yes 2□ No	3□ Pro	bably 4 Unknow
Records,	law requires that es been signed to 2 should be det	Completed t	· val	Ve Re	pla	cen	nens	24e. Wes perfo	an autopsy ermed?	8/	Vere eutopsy findings veileble prior to empiation of causa daeth?
	The ate h		Cirrhasi	8 071	レル	02_		10	Yes 22 No	11	☐ Yes 2☐ No
of Vital	Physician: The this certificate ral director, pa	Be	25. Wes casa referred to medical examinar?	tospitel:		_ 0	thar	eath (Check only o			
of	Phys this rai di	. To	1 Yes 20 No 27. Mannar of Deeth	28e. Data of Injury	ER/Outpatien	T 3LI DOA	4 LI Nursing	Homa 5 Resid	dence 6 □Oth how Injury occur		fy)
	ding F th. After funer	tlon	1 Pending 5 Pending	(Month, Day Yaar) Injury	28c. Inje W	ork? □Yas 2□No	200. Describe	now injury occur	100	
Division	To the Hospital or Attanding Physician: within 24 hours effer deeth. To the Funeral Diractor: After this certificacompletely filled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be datarmined	28a. Place of Injury - A building, etc. (Spe	t home, farm, streecify)			28f. Location (S City or Tox		ber or Run	al Route Number,
	pital ours e srai E filled	S	200 Cordina	lates T. de test							
	To the Hospital within 24 hours of To the Funeral I completely filled	edical	29e. Certifiar (Check only one) Certifying Physical Certificity Physical Certificity Phys	elician: To the best of my keer: On the basis of exem	inowiadga, deeth inetion end/or Inv	occurred et the frastigation, in my	opinion, daath occ	a, end dua to tha urred et the time,	causa(s) and made end place,	annar as s and dua t	natad. o tha cause(s)
	To the Within 2 To the comple	Me	29b. Signature end title of certifier) in the control of t		29c Licer	nse number		29d. Data signe	d (Month	Dav. Year)
	FXFS			(ati	0		77/7	>11	1-7	7_	90
	3		On Name and address of	- per	1		-505	7	' /	-/-	181
			30. Name end eddrass of person who co	mpiated cause of death (I	tem 23e) (Type,	rrint)					

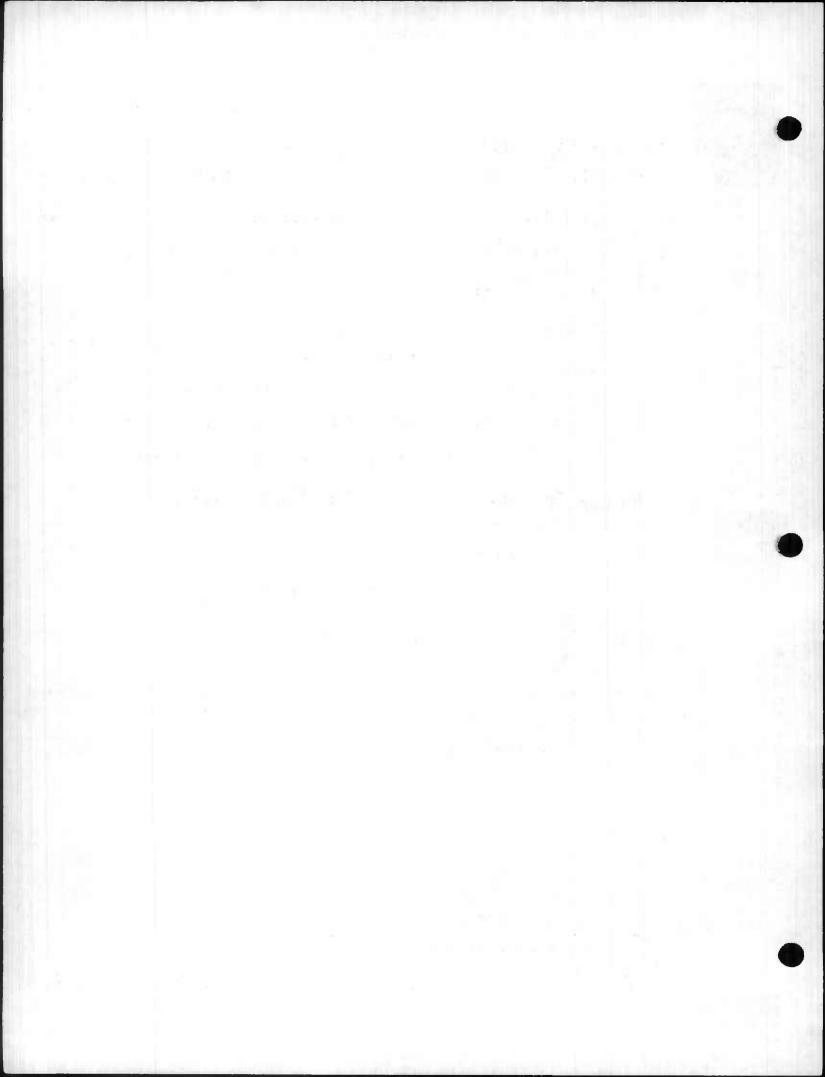
State Registrar 31. Date filed (Month, Day, Year) JAN 29 1998

PHILIP J.BEAN MEDICAL CTR. HOLLYWOOD, MD. 20636 ADINATH A. PATIL M.D.

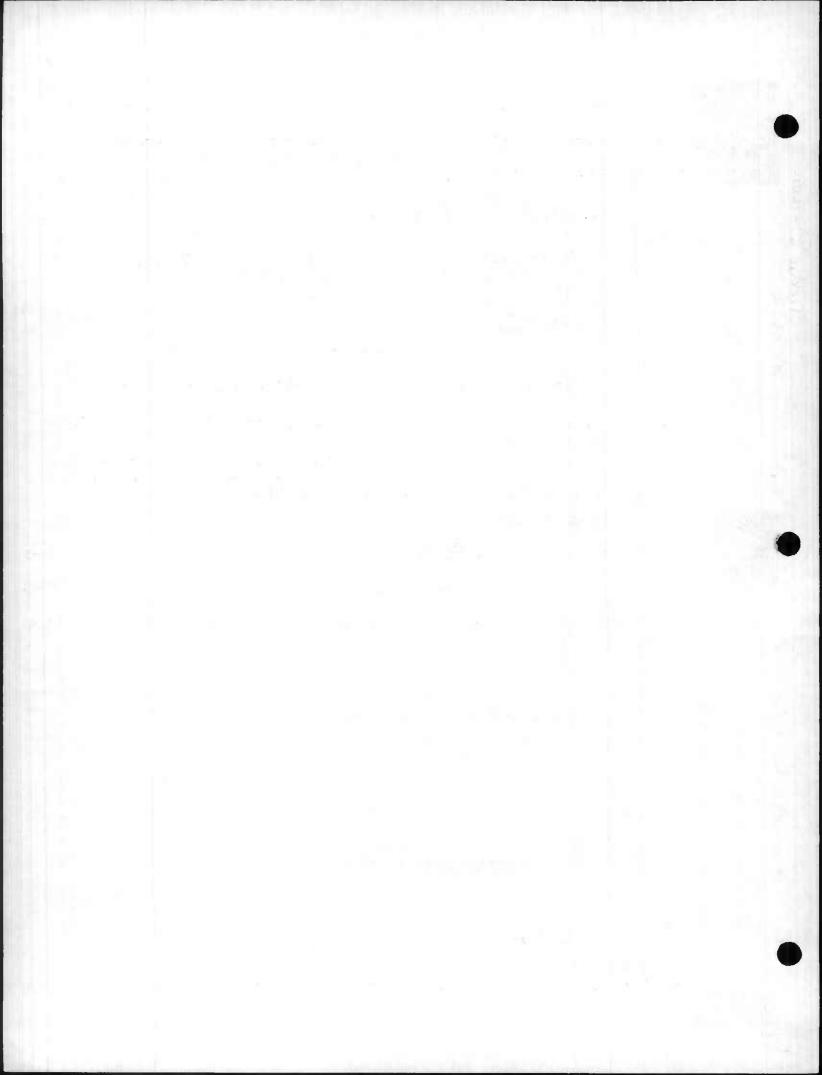


Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	h		Reg. No.		0 2 0 3 7
Dhuniafa		Decedent's Neme (First, Middle, Last)		2. Dete of D	eeth Dev	Yeer	3. Time of Death
Physicia /Medic		Ruben DeGroat		Jan.		998	11:40 p
Examin		4a. Fecility Neme (If not institution, give street end number) 4b. City, T	Town, or Lo	cation of Dee	th 4c. Coun	ty of Death	•
			ston			bot	
Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours 1 4 5 - 0 3 - 88 9 5 1 M 2 F 7. Age (In yrs. lest birthday) 7 8 Yrs. Usual Residence of Decedent	er 24 Hrs. Min.	8. Date of B (Month, D 0 2 / 0	irth Pey, Year) 7/19		place (Stete or Foreigr ntry) Jersey
wo man		10e. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
the Marylen 28a-f show	Director	MD Caroline Federa 10e. Street and Number 10f. Zip Code	lsbu	rg	40- 04	140-10-1	1 ☐ Yes 🏋 ☐XNo
eth with s 23e or nut be	rai Dir	3829 Houston Branch Road 216			United	Sta	tes
020 urs e	d by Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Ves 2 □ X No Specify 1 □ Yes 2 □ X No Specify	jy:		o- 14. He Bi	eck, White,	can Indien, etc. hite
5-(Completed	15. Decadent's Education (Specify only highest grade completed) [Second Continuous Cont	ost of worki	ing	16b. Kind of	3usiness/1r	dustry
2121 d within giene.	mpi	Elementery/Secondary (0-12) College (1-4or 5+) Postal Employe			U.S.	Post	al Svc.
12 y	ပ္ပ			/Fine Adiabat	e. Maiden Sume		
	Be			Sher		me)	
Marylar d 2 should by th end Menta 7 is marked traumatic ex	ဥ	19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Numb				· Ctota 7	0160
CHUP		Helen F. DeGroat/Spouse 3829 Houston B		h Rd.	, Fede	rals	burg, MD
0 80 = 5		20e. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 20b. Placa of Disposition (Name of cametery, cremetory or other place) Hill Crest Cemeter	y 1	/ 2 5	Federa		rg, MD
Baltim pemit. Pa Departmen Important: any Injury		21. Signeture of Funeral Servica Licansee Multiple 7. Eshare 22. Name and Address of Feci Framptom-Haw PO Box 43, F	kins eder	-Esko	w Fune	ral 216	Home 32
Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting In death) Premove and Due to (or es e consequenca of):	anla	oven	lipe	SP.	2 days
68760, rifficete be executed ng physician end as the burial-transit	Ical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events of the constant of the const)		
	in/Medical	d					
. 5 . 5	slcie	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert	t I.	23b. Did	tobacco uee c	ontribute t	o the cause of death
that the death ce led by the ettendial deteched for use	Physician/	Consective Lout Failure		10	Yes 2□ No	3 Pro	bably 4 Unknow
v 8 5 8	Completed by	Prostate caremona			s en eutopsy formed?	6/	fere eutopsy findings reileble prior to empletion of cause
The law ate hes be pege 2 s	du						deeth?
VITAL Ilcien: The certificate rector, peg	Co	25. Was asso referred to medical	(D		Yes 220 No	1	☐ Yes 2☐ No
Of VITa Physicien: this certific ral director,	00	examiner? Hospital: Other:		(Check only			
Ing Phys	on: To	27. Manner of Deeth 1 Naturel 5 Pending 28. Dete of Injury (Month, Dey Year) 29. Detection 1 Death (Month, Dey Year) 29. Time of Injury Work?			how Injury occu		(y)
DIVISION Of VITA Within 24 hours effer death. To the Funerel Director: Affer this certific completely filled in by the funeral director.	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide M 1 ☐ Yes 2 ☐ 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)		28f. Location City or To	(Street end Nun own, State)	ber or Rur	al Route Number,
Hospital 124 hours Funeral Hetaly filled	edical	29a. Certifler (Check only one) Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete e and menner steted.	end place, e	end due to the	e cause(s) end n	nenner es : , end due t	steted. o the cause(s)
To the within 2 To the comple	Me	29b. Signature end title of certifier 29c. License number 03974	19		29d. Date sign	ed (Month,	Dey, Year)
		30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)	ens'	Lone	Cest	5-	ms 2160/
Stat Registra	100	31. Dete filed (Month, Dey, Yeer) JAN 23 98 32. Registrer's Signature JAN 23 98					

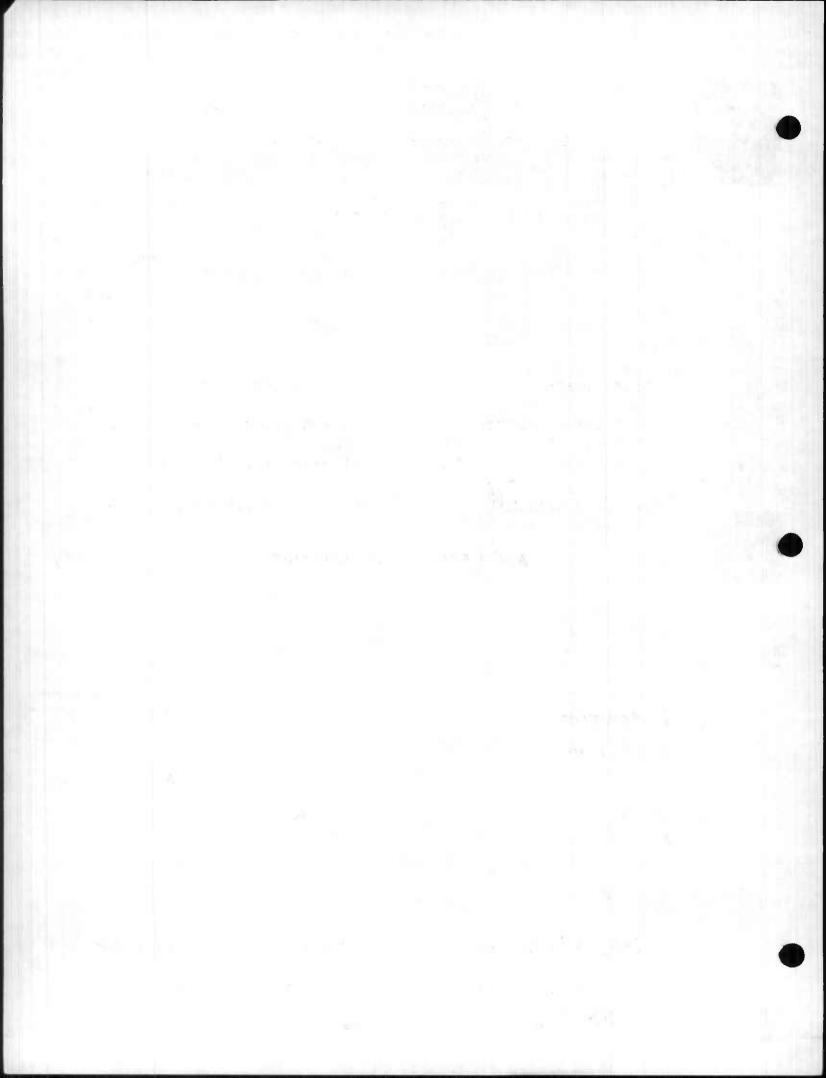


					Cei	rtificate	of i	Death		Reg. No.		- 0	20
Physicia	٦	1. Decedent's Name (First, Middle,							2. Date of De Month	ath Day	Year	3. Tim	ne of Death
Medica	_	Nellie V	. Deneau	1					Jan	20 1	998	3:	56P
kamine	er	4a. Facility Name (If not institution,						lb. City, Town, or I	Location of Deat				
Щ	Ц	The Memoria						Easton		Tal			
eral			. Sex 7. Ag 1 M 2 F	ge (In yrs. last b	virthday) Yrs.	If Under 1 Months D	Year Days	If Under 24 Hrs. Hours Min.	(Month, De				ate or Foreig
tor		216-10-6775 Usual Residence of Decedent	Λ	89	110.				July	31,190	8 Ma	ryl	and
		10a. State 10b. County		10c. City, To	wn or Lo	cation					1	10d. Insic	de City Limits
	ō	Md. Carol	ine	Fed	era	Isburg	g					1 🗆	Yes 2 No
	Director	10e. Street and Number				10f. Zip Co	ode			10g. Citizen of	What Cour	ntry?	
		27361 Wil	lin Lane				216	532		U.S.A			
	Funerai	11. Marital Status	12. Was Decedent	Ever in U,S.	13.)			ispanic Origin? (S In, Mexicen, Puert	pecify Yes or No	- 14. Rad	e - Americ		n,
	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 Armed Forces? If Yes, Give Armed Forces.	No		f Yas, specify 1 ☐ Yes 2 ☑			o Rican, etc.)	Specif	ck, White,		
	De le	15. Decedent's	Education	166	a. Deced	ient's Usuel C	Occup	ation		16b. Kind of B	uslness/In	dustry	
	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	kind of work of DO NOT use i	done d retired	ation du <i>ring m</i> ost of wor f)	king				
	5	8	o one go (1 tot	.,	Hom	emake	r			Own I	lome		
	Be	17. Fathar's Name (First, Middle, La		1974				18. Mother's Nen					
	0	W.	illiam L.	Trice				Lillie	e Willi	amson	Tri	се	
		19a. Informant's Name/Ralationship						and Number or Ru					
		Forrest P. De	eneau	2	227	2 Hav	er	camp Ro	ad, Pr	eston,	Md.	. 21	655
		20a. Method of Disposition 1 Durial 2 □ Cremation 3	□Bomousi from State		of Dispo	sition (Name natory or othe	of or plac	e)	Date	20c. Location	- City or To	own, Stat	a
6		4 Donation 5 Other (Spa		Juni	or	Order	C	emetery	1/24/	98 Pre	stor	n. M	1d.
8		21. Signature of Funeral Service Llo	A		22	. Name and A	Addre	ss of Facility Fe	leralsh	urg, M	1d. 2	2163	32
8		Michael 7.	Eskew		Fr	ampto	m -	Hawkins	-Eskow	Funer	all	lome	
	al Examiner	Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed avents	a	EPSIS Due to (or es e /EVMO Due to (or as a	consequence	uence of):	7	INF	ECTION	/		48	imate l Between and Deeth l bug Hour
	Physician/Medical	resulting in death) Last Part II. Other algnfficant conditions	dcontributing to death b		in the ur	ndartying caus		en in Part I.		tobacco use co Yes 2□No			use of death
3	2		VLICE	2 / (1	2011/7	<i></i>						
	3160								24a. Was	an autopsy rmed?	av	eileble pr	psy findings rior to of causa
200	d l											death?	01 02032
and a	5								1 🗆	Yes 2 No	10	Yes	2 No
and and		25. Was case referred to medical examiner?						26. Place of Dea	th (Check only	one)			
5	0	1 ☐ Yes 2 D No	Hospital:	ant 2 ER/O	utpatien	t 3 DOA	Oth	er: 4 Nursing H	ome 5□Resi	dence 6 □Oth	er (Specif	y)	
led in by the funeral	rilication:	27. Manner of Death 1 Natural 5 Pending investigat 3 Suicida 6 Could not determine	ba 28e. Place of Inj	y Year)	Time of Injury	М		/ at k? Yes 2 □ No		how Injury occur Straet and Numb vn, State)		al Route i	Number,
pietery lined		29a. Certifier 1 Cartifying I	Physicien: To the best aminer: On the basis of and manner st	f examination e	je, death nd/or Inv	occurred at t	the tim	ne, date and place pinion, deeth occu	, and due to the rred et the time,	cause(s) and mo	enner es s end due to	tated.	se(s)
	100	29b. Signature and title of certifier	Bener			29c. L		2635	0	29d. Data signe	od (Month,	Day, Yes	ar)
State Registrar	9	30. Name and address of person when William S. B. 31. Data filed (Month, Day, Year) JAN 23 '98	remer. 80		alb	ot St	. ,	St. M	ichaels	s, MD			



State of Maryland / Department of Health and Mental Hygiene 8 0 2 6 9 6

				Ce	rtificate of	Death	Re	g. No.	C) to	
		1. Decedant's Nama (First, Middla, La	st)				2. Data of Death			3. Tima of Death
Physic		VICTORIA OU	EENIE EVE	RSLEY			JANUAR	7,19	Yaar 998	12:55pm
/Medi Exami		4a. Facility Nama (If not institution, give				4b. City, Town, or		4c. County	-	12.33pm
Exami	iei	CORSICA HILLS		NTER		CENTRE	VII.I.E			N ANNE
Francis		5. Social Sacurity Number 6. S			if Undar 1 Yaar			,	-	
Funeral Director			□M 2©F 92	Yrs.	Months Days	Hours Min.	(Month, Day, AUG • 2			laca (Stata or Foraig try) MD
ylan		10a. Stata 10b. County	10c. C	ity, Town or L	ocation				1	0d. Insida City Limits
Mar T	tor	MD. QUEEN	ANNE	CENT	REVILLE					1 X Yas 2 □ No
r 28	Director	10e. Street and Number			10f. Zip Coda		10	g. Citizan of V	What Coun	itry?
3a o		104 JONES STRE	ET			21617		776	7.7	
me 2	Funeral	11. Marital Status	12. Was Decadent Evar in U	J,S. 13.		Hispanic Orlgin? (S oan, Maxican, Puart	pecify Yas or No-		e - Amaric	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Items 23s or 28s-1 show or other traumetic event, If a Madical Examin for must be notified at	by Fur	1 ☐ Navar Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Armad Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas:		If Yas, specify Cut 1 ☐ Yas 2 X No		o Rican, atc.)		k, Whita, BL	
ture all		15. Decadant's E		16a. Dece	dent's Usuel Occu	pation	1	6b. Kind of Bu	usinass/Inc	dustry
d within 72 hours af giene.	Completed	(Spacify only highast gra	ada complatad)	(Giva	kind of work done DO NOT usa ratin	during most of wor	king	ob. Kind of be	251100571110	Judity
within ene. then	E	Elementary/Secondary (0-12)	Collaga (1-4or 5+)	NUR	SE			HOSE	PITA	r.
Hygi Hygi		17. Fathar's Nama (First, Middla, Last)	11011	0.13	18. Mothar's Nar	na (First, Middla, M			
d be	Be C	ARTHUR JOHNS				ELIZA		JNDY		
should be and Mental marked of umatic eve	To	19a. Informant's Name/Relationship (10h Maili	na Addresa (Ctros	t end Number or Ru			Ctata 7ia	Code
nd 2 should be file Ith and Mental Hy 27 is marked oth traumatic event				190. Maii						
permit. Pages 1 end Department of Health Important: If Itam 27 any Injury or other tr once.		MARY BROOKS 20a. Mathod of Disposition	/ NEICE	Place of Disne	104 JO osition (Nama of	NES ST.		Oc. Location -		
Pages nent of h		1 Burial 2 Cremation 3		cematary, cre	metory or other pla	ace)	Data	oc. Location -	City of 10	wii, Stata
4 # 6 2		4 Donation 5 Othar (Spacif	y) ST	. PET	ERS CEM	ETERY 1	/14/98 (UEENS	TOWI	V, MD
permit. Departm Departm Importar any Injui		21. Signatura of Funaral Sarvice Licar	nsaa 🔪 🐧		2. Nama and Addr					
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sand al-tra	Xa	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying	Dua to (or as a conse	quance of):					
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thet the death cert ed by the attendin deteched for use	by Physician/									
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or Attending Physicien: The lew requires to effected at the requires to effected at the certificate has been signed in by the funeral director, page 2 should be	Completed	DYSPHAGIA					24a. Was an perform	autopsy ed?	ava	ara autopsy findings ailabla prior to
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or Attending efter death. Director: After I in by the fune	cat	2 Accidant invastigation 3 Suicida 6 Could not b	9				00/ 1 /0			10
or At efter Direct In by	E	4 Homicida datermined	28a. Placa of Injury - At h building, atc. (Space		raat, factory, office		28f. Location (Streetly or Town,	Stata)	er or Hura	I Houra Number,
is e le										
t hou	edicai	29a. Cartifiar 1 Certifying Ph	yalclan: To tha best of my kno ninar: On tha basis of axamina	owledga, deat	h occurred at the t	ime, date end place	, and dua to tha car	use(s) and ma	annar as st	tated.
To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: Affer this certificate his completely filled in by the funeral director, pege	ed	one)	and mannar stated.		Juganish, mility		with think, the	una pravo,		
To t To t	Σ	29b. Signatura and titla of cartifiar			29c. Lican	sa number	29	d. Data signe	d (Month,	Day, Yaar)
		1 Sunt	thems		D	41587		1/9	9/98	5
		30. Nama and address of person who	complated cause of death (Ital	m 23a) (Type						
						CMEDMATT	T MD 010			
		HELEN A. NOB	JE, MD 122 S		KD. CHE	PIEKI,OMI	N,MD.216	120		
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Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** MARTHA COUNCELL ELLIOTT January 3, 1998
coation of Death 4c. County of Death /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death Examiner The Memorial Hospital Easton Talbot 5. Social Sacurity Number If Under 1 Year If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months Hours Yrs 218-09-3140 Director 80 NOV. 26,1917 Usual Rasidance of Dacadant 10a. Stata 10c. City, Town or Location 28a-f show traumatic event, the Medical Examinar must be notified at Director MD TALBOT EASTON 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda 23a or 2 113 PARRIS LANE 21601 Funeral USA daath Herne 12. Was Decedant Evar in U,S. Armad Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian. Black, Whita, atc. 1 ☐ Yas 2 X No If Yas, Giva 1 Nevar Married 2 Married "natural", or Martha Elliott Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Spacify. by Specify: 3 ☐ Widowed 4 ☑ Divorced Yaar or Datas Completed 15. Dacedant's Education (Specify only highast grada completed) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry permit. Pagas 1 and 2 should be filed within Department of Haalth and Mantal Hygiana. Important: If item 27 is marked other than any injury or other traumatic event, the Magnes. Elemantary/Secondary (0-12) College (1-4or 5+) 11 -0-BOOKKEEPER BOTTLED GAS 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be THOMAS H. COUNCELL CECELIA SLAUGHTER 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 113 PARRIS LANE, EASTON, SHERRY E. GOODMAN MD 21601 20b. Place of Disposition (Nama of cematary, crematory or othar place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 1-7 EASTON, MD 21. Signatura of Funaral Service Licensee 22. Nama and Addrass of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME Mam 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. HARRISON ST. EASTON, MD 21601 Approximate

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3

Physician /Medical Examiner

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signed by the a

page 2 certificata has

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neral Director: After this villad in by the funeral di

To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th complately filled in by the funeral

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Completed

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Certification: To

The law requires that the death certificate be executed

68760

Box (

P.O.

Records,

of Vital

Division

Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiata ceuse. Entar Undarlying Cause (Disaasa or injury that initiated events rasulting in daath) Last

Immediate Causa (Final disaasa or condition rasulting in death)

Dua to (or as a consequence of)

3. Tima of Death

MARYLAND

WHITE

10d. Insida City Limits

XYas 2 No

2:55PM

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Ware autopsy findings availabla prior to completion of ceusa of death? 24a. Was en autopsy parformad' 1 Yas 2 No

1 ☐ Yas 2 ☐ No

23b. Did tobacco use contributa to the cause of death?

25. Was casa rafarred to medical axaminar? 1 Yas 2 No 27. Mannar of Death

Hospital: 1 Impatiant 2 ER/Outpatient 3 DOA 5 Panding invastigation

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

29a. Cartifier

1 Natural

2 Accidant

3 Suicida

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceusa(s) and manner as steted.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and manner stated.

29b. Signatura and titla of certifian

29c. Licansa numbar

26. Place of Death (Chack only one)

29d. Data signad (Month, Day, Year)

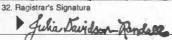
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

ns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

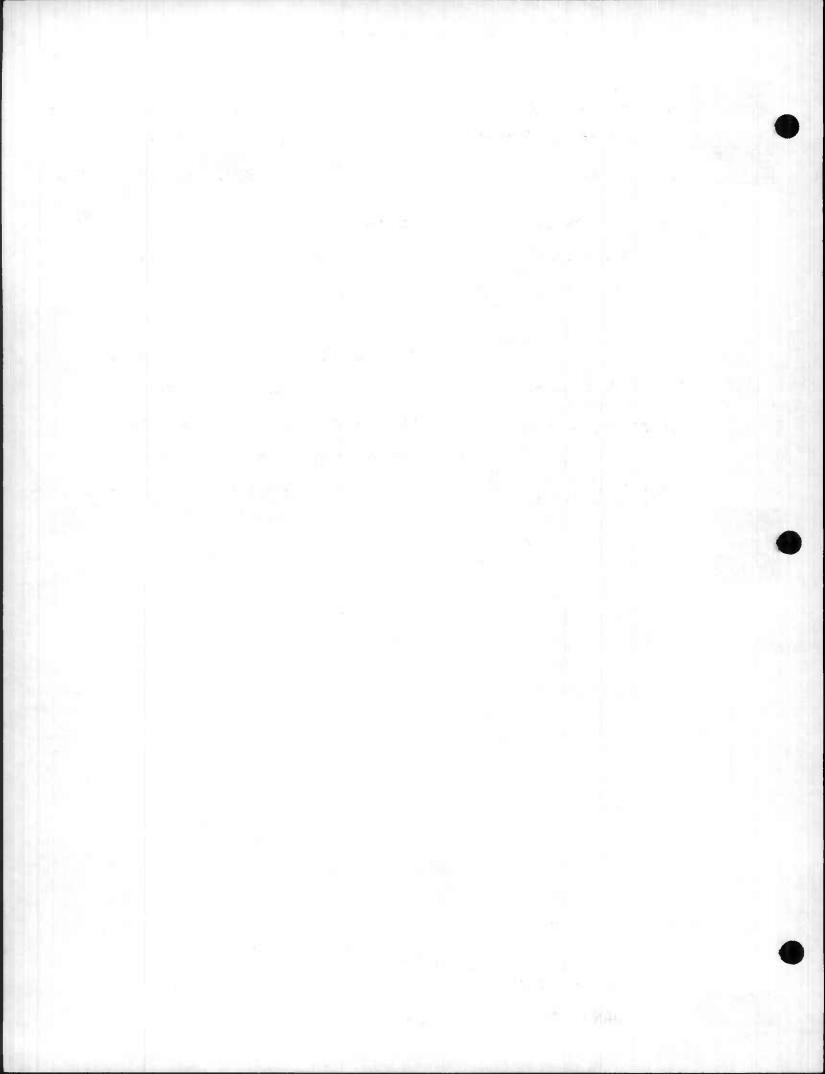
FAUNTLEROY, THOMAS W. M.D., 403 MARVEL COURT, EASTON, MD 21601 31. Data filed (Month, Day, Year)

State Registrar

6 Could not be datarmined



28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death EVERETT Month Yaar **Physician** MAR 7:55pm 4b. City, Town, or Location of Death 74c. County of Death 211998 /Medical 4a. Facility Nama (If not institution, giva street and number) **Examiner** Washington Adventist Takoma Park Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day Year) | July 13, 1946 5. Social Sacurity Number Birthplaca (Stata or Foraign Country)
 NC 6 Say 7. Aga (In yrs. last birthday) **Funeral** 1 ☐ M 201F Yrs 51 Director 577-62-9443 Usuel Residence of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits nam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 X Yas 2 No Director NA Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3543 6th Street, N. W. 20010 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Spacify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Detes: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 **Black** 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry permit. Peges 1 and 2 should be filed within:
Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than any Injury or other traumate. Elementary/Sacondary (0-12) 10th College (1-4or 5+) Clerk Typist Private Industry 17. Fethar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Elwood Branch Lila Vinson 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3543 6th Street, N.W., Washington, DC 20010 Jesse J. Everett - Husband 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ♣ Ramoval from Stata 2/1/98 4 ☐ Donation 5 ☐ Othar (Specify) Bishop Cemetery Mapleton, NC 22. Nama and Addrass of Facility
R. N. Horton Co. Morticians, Inc.
600 Kennedy Street, N.W., Wash., DC 20011 21. Signatura of Funerel Sarvice Licensaa R. M. Hoston 23a. Part1. Entar tha disease, or complications that caused the deeth. Do not entar the mode of dylng, such es cardiac or raspiratory arrast, shock, or heart feilure. List only one cause on each line. e. Lepticlma with Klebsiella

Dua to (or as a consequence of):

Diabetes Mellitm, easonic Renal failus;

Dua to (or as a consequenca of): and 15 calenic Gangsone

A fainds Physician /Medical Immediata Causa (Final disaese or condition resulting in death) Examiner physician end the bunel-transi Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Causa (Disaase or Injury that initiated evants rasulting In death) Last Box 68760 Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Records, P.O. the 1 Yes 2 No 3 Probably 4 Unknown After þ ppe 6 + ensin 24a. Was an autopsy performed? 24b. Were eutopsy findings availebla prior to complation of causa of daath? Peripheral vasenlas Distala 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case rafarred to medical axaminar?
1 ☐ Yas 2 ☐ No Be 26. Placa of Death (Check only ona) Hospital: 1 □ Inpatiant 2 □ ER/Outpetient 3 □ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: After 5 Pending invastigation 1 Natural death. 1 ☐ Yas 2 ☐ No Director: A 2 Accidant 6 Could not be datermined 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 3 ☐ Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) To the Hospital or A within 24 hours effer To the Funeral Directompletely filled in b 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

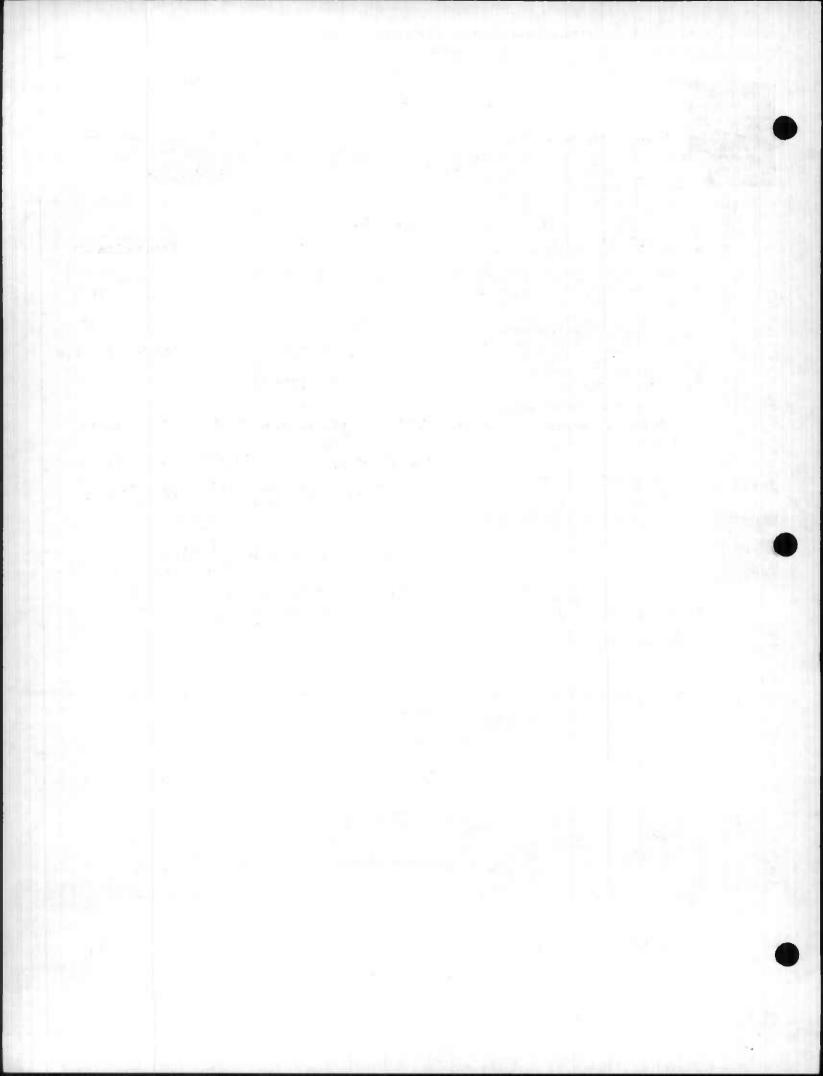
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Cartiflar Medical (Check only one) 29b. Signeture end titla of certifiar 29d. Date signad (Month, Day, Year) A. Mannan MD 24593 3331 - TOLEDO TERRACE HYATTSVILLE, MD, 20782 30. Name and addrass of person who complated cause of death (Item 23e) (Type, Print)

32. Registrar's Signatura

Julia Davidson Randelle

DHMH 16 Rev 6/95

State

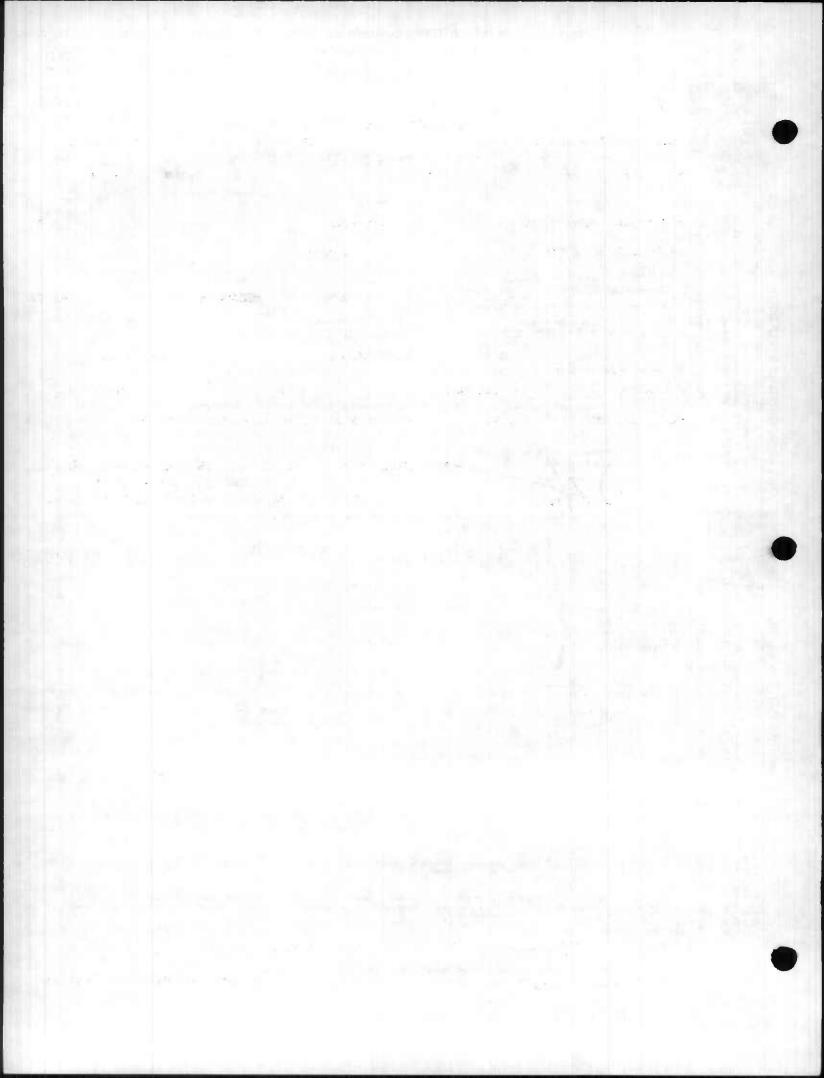


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 01 TNGELINA -NSENAT /Medical 4a Facility Name (If not institution, give street and number) HAMMONDS LANE 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CENTER GENESIS ELDER CARE BROOKLYN PARK ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) 09-14-1895 9. Birthpiece (Stete or Foreign Country) ITALY 6. Sex **Funeral** 10M 20 F 213-28-8671 102 Yrs. Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner main to notified at 1 ☐ Yes 2 ☐ No Director MARYLAND ANNE ARUNDEL LINTHICUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6439 ORCHARD ROAD 21090 U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 15 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2X No Specify: WHITE by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 end 2 should be filed.
Department of Health and Mental Hygi
Important: If Item 27 is marked other is
eny Injury or other traum-41-17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) SALVATORE TESTUDINE ANNA (UNKNOWN) 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) PETER ENSANAT 6439 ORCHARD ROAD, LINTHICUM, MD. 21090 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donetion ■ Other (Specify) GLEN HAVEN MEMORIAL PARK 1/22/98 GLEN BURNIE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, 21. Signature of Funeral Service Licenses 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician ALZHEIMER'S DISTASE /Medical Immediate Cause (Final disease or condition resulting in death) 10 YRS Examiner Due to (or es e consequence of): Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): Box 68760 Physician/Medicai that initiated events resulting in death) Lest Due to (or as a consequence of) esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. OBSTRUCTIVE 1 Yes 2 No 3 Probably Ø Unknown PULMONARY DISEASE. CHROMIC signed b à 24b. Were autopsy findings evailable prior to Completed 24e. Wes en eutopsy completion of cause of death? 1□ Yes ⊅GNo 1 ☐ Yes 28 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide Hospital of 24 hours a Funeral D 29a. Certifier (Check only one) 1🛛 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the cause(s) end menner es steted. Medical To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 19 Danners, mo D17753 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K'S DHARMASENA, MOD. 710 CHURCH ST. BALTIMORE, MD 21225 31. Date filed (Month, Dey, Year)
JAN 2 0 1998 12 Pogistrer's Signature the Davidson Pandall Registrar

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 0.8 0.2700

				C	ertificate d	of Death		Reg. No.	U	2100
Physicia	an	1. Decedent's Neme (First, Middle, Les STEVEN HA	D h i D	EI	HELBA	LIM	2. Dete of De Month	eth Dey	Year	3. Time of Deeth
/Medic Examin	al	4e. Fecility Name (If not institution, give			THE LIDE	4b. City, Town, or BALTIN		4c. County	198 of Deeth	5.25pm
Funeral Director		5. Social Security Number 6. Social Security Number 11 6. Social Security		yrs. lest birthd	Months De	ar If Under 24 Hrs	8. Dete of Bir		9. Birthple Countr Vir	ece (Stete or Foreign ry) ginia
anyland show	_	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town o					100	d. Inside City Limits
the M	Director	VA None		Nor	folk			10g. Citizen of W	hat Caustr	
h with		7404 Millbrook Ro	ad		235					s of Amer
72 hours after death with the Maryland netural', or terms 23a or 28a-f show pical Examiner must be notited at	by Funeral	11. Maritel Stetus 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Yeer or Dates:	in U,S.	3. Wes Decedent If Yes, specify C	of Hispanic Orlgin? (Scuben, Mexican, Puerl	pecify Yes or No o Rican, etc.)		- America c, White, et	n Indien,
d within 72 hours piene. r than "netural", tre Medical Exe	Completed	15. Decedent's Ed (Specify only highest gred Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	(G life		ne during most of wo tired)	rking	16b. Kind of Bu		
- A - F		17. Fether's Name (First, Middle, Last)	-4-	Se	1f-Emplo		ne (First Middle	Atlanti Maiden Sumeme		posal, Ir
d d d	To Be	Joseph Eichelbaum	والمرافع والمرافع				Schapir		,	
th end 7 is m traum		19a. Informent's Name/Relationship (7 Lisa Eichelbaum -	,, ,, ,, ,,			eet end Number or Rook Road,	ıral Route Numb	er, City or Town,		
Peges 1 end 2 nent of Health nt: If Item 27 I nry or other tra		20e. Method of Disposition 1 XXuriel 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removel from State	cemetery, o	sposition (Neme of cremetory or other awn Ceme	place)	Date January 5, 1998	20c. Location - 0		
Department Important: I any injury o		21. Signature of Funerel Service Licens	D. War	e	22. Name end Ad	dress of Facility H.	D. Oliv	er Funer nial Ave	al Ap	ts., Inc
Physician /Medical Examiner the prive transit transit	Examiner	23a. Pent1. Enter the disease, or compence, or heart failure. List only of the disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse, (Disease or injury	a. DIPPUSE A DUO DUO DUO DUO DUO DUO	LVEOL to (or as e con UEIC to (or es e con	AR DEN sequence of): BONE N sequenca of):		RANSPL	ANTATION	3	Inferred Batween Onset end Deeth Ro DAYS 49 DAYS 6 MONTH
hat the death certified by the attending deteched for use es	Physician/Medical	resulting In death) Last	d.	o (or es e con	sequence of):			tobacco uee con		the caues of death
8 5 8	Completed by						24e. Wes	en autopsy rmed?	com	re eutopsy findings ilebte prior to opletion of cause eeth?
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tending Physical Cor: After this the funeral d	ation: To	27. Manner of Deeth 1 Natural 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Yea	2 ER/Outpa 28b. Time Injur	e of 28c. i	njury et Nork?		dence 6 Othe		
tal or Attending 's efter death. al Diractor: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Piece of Injury - Abuilding, etc. (Sp.	At home, farm, ecify)	street, fectory, offi	се	28f. Location (City or To	Street end Numbe vn, Stete)	or or Rural	Route Number,
Funer Funer tely fill	edlcai	29e. Certifier (Check only one) Certifying Phy 2 Medical Example (Check only one)	reiclan: To the best of my Iner: On the besis of exer- end menner steted.	knowledge, de ninetion end/or	eeth occurred et the r investigation, in n	e time, date end plece by opinion, deeth occu	, and due to the irred et the ti <i>m</i> e,	ceuse(s) end mer dete end place, e	nner es ste nd due to t	ted. the ceuse(s)
To the To the comple	Σ	29b. Signature end title of certifier	ray MD			ense number 17953		29d. Date signed		
		30. Neme end eddress of person who c	ompleted cause of deeth	(Item 23e) (Typ		VOLPE ST				
Stat	e	31. Dete filed (Month, Dey, Year)	32. Registrer's S	igneture	LOO	UULIE SII	ull, D	116/1/116	KL	

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State of Maryland / Department of Health and Mental Hygiene 98 02701

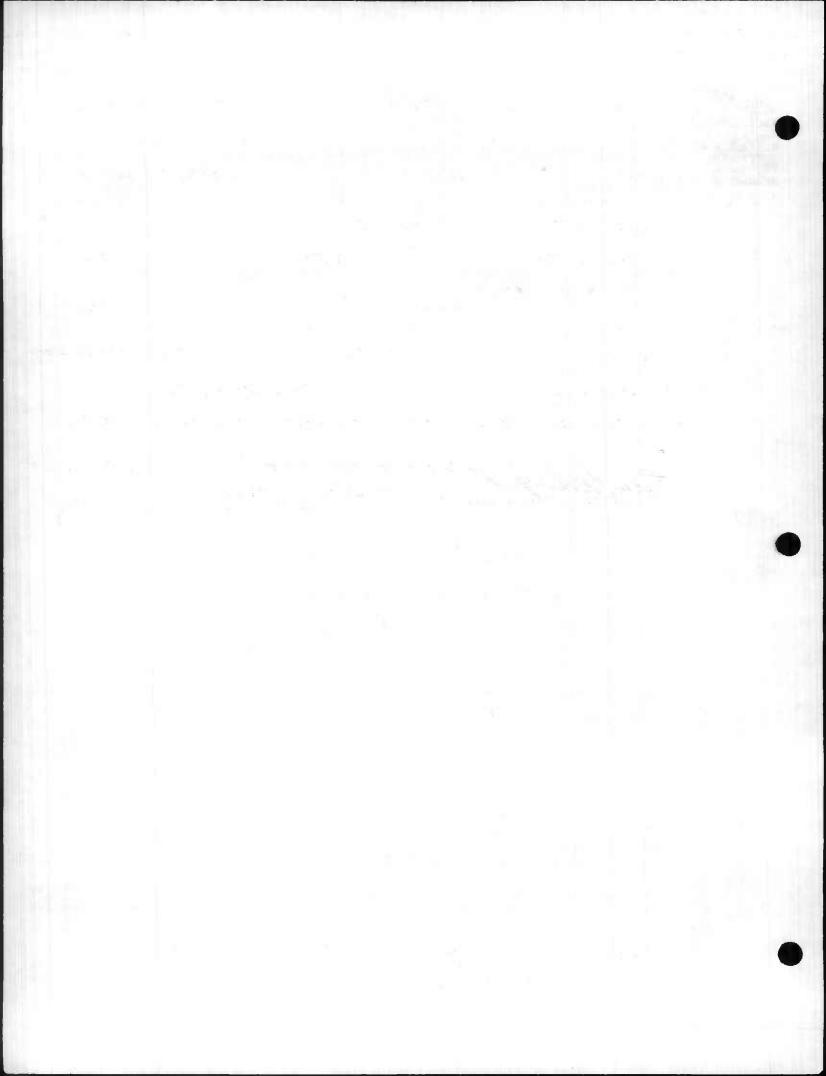
						Certificate of	of Death		Reg. No.		-101
			1. Decedant's Nama (First, Middla, L	ast)				2. Data of De	eth	Win	3. Tima of Death
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Т	Funeral	п		Sex 7. A	ga (In yrs. last birth		ear If Undar 24 Hrs	8. Dete of Bir			ace (State or Foreign
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	ahow		10e. Stata 10b. County		10c. City, Town	or Location				10	Od. Insida City Limits
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	1 2 2 E	Director	10e. Street and Number			10f. Zip Cod	~		10g. Citizen of	What Count	try?
	7 Wil		207 Caroline	Street		2	2401		US	SA	
	990	Funerai	11. Marital Status	12. Was Decedant Armed Forces	Evar In U,S.	13. Was Decedant	of Hispanic Origin? (S Cuban, Maxican, Puar	specify Yes or No)- 14. Rad	ce - America	
	be filed within 72 hours effer deeth with the Maryland stal Hygiene. d other than "natural", or flems 23e or 28e-f ahow event, the Medical Examinan must be notified at	by	1 ☐ Nevar Marriad 2 ☐ Married	1 Yas 20 If Yas, Giva Year or Datas:		1 ☐ Yes 2X		to riloan, ato.)	Specif	ck, Whita, a	
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mai yiaiia	Meni	2	Robert Lindsay	Jaynes			Con	rinna Mi	ller Ga	rdine	r
3	. 6 0 2		19a. Informent's Name/Relationship	(Type, Print)	19b. I	Mailing Addrass (Str	reet and Number or R	ural Routa Numb	er, City or Town	, Stata, Zip i	Code)
	5 4 T		Margaret Clapp	(Daughter)	12	3 Cardamo	n Drive	Edgewate	r, Mary	land :	21037
	of Heelt of Heelt Item 2		20a. Mathod of Disposition 1 ☐ Burial 2XX Cremetion 3			Disposition (Nema or crematory or other	f place)	Data	20c. Location	- City or Tov	wn, Stata
	Pege nent c int: If iny or		4 □ Donetion 5 □ Other (Spec			ncoln Cre	matory 1	-15-98	Brentwo	ood. M	Maryland
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ò			23a. Part1. Entar the diseasa, or conshock, or haart tailura. List onl	nolications that cause	d the deeth Do no				-	-	Approximata
	xaminer u and l-transit	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury	a	Due to (or as a co	nsaquanca of):	failu		cove		72002
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	es mat the death igned by the ette be detached for	lys	Part II. Other significant conditions	contributing to death t	out not resulting in t	ha undarlying causa	givan in Part I.		_/		the cause of death
	mar ded to dete		Verment	2 -	Mr 4-	lais		1	Yee 2 No	3∐ Prob	ably 4 ☐ Unknow
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	s efter of Mi Direct	Certif	4 ☐ Homicide datarmine	28a. Place of in	jury - At home, ferm lc. <i>(Specify)</i>	n, streat, factory, offi	ice		Street and Numi wn, Stata)	ber or Rural	Routa Number,
1	vithin 24 hours efter death To the Funeral Director: completely filled in by the	edicai	29a. Certiflar (Check only one) 1 Certifying P 2 Medical Exs	hysician: To the best miner: On the basis of and manner st	t axamination and/	death occurred at the or Invastigation, in m	e time, data and place ny opinion, daath occu	, and dua to tha urred at tha tima,	causa(s) and m data and placa,	annar as ste and due to	eted. the ceuse(s)
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			30. Nama and addrass of person who	completed cause of	death (Itam 23a) (To	(ne Print)					
			Peter F. Verkou				v Annanal	e Mn o	1/101 (/.	10-57	3_1110)
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

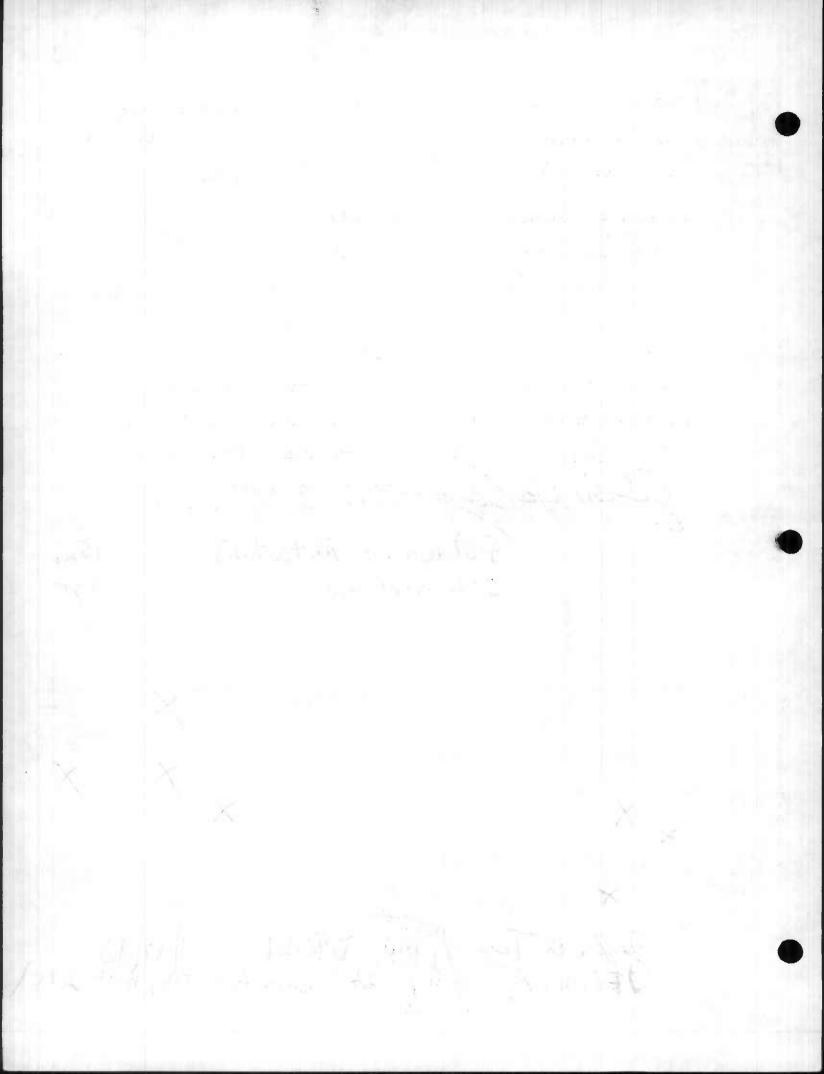
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	Exami		4e. Fecility Name (If not institution, gi								ocation of Deel		y of Deeth vert		
	Funeral Director		5. Sociel Security Number 6. 404–18–9502	Sex 1 M 2 F	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1	Year		_	8. Dete of Bi (Month, D		9. Birthp	ilece (Sta itry) icky	ite or Foreign
	with the Maryland o or 28a-f show be notified at	ector	Usuel Residence of Decedent 10a. State 10b. County Maryland St. M	lary's		ity, Town or Lo	Point							1 🗆 Y	e City Limits
	death with t	Funeral Director	10e. Street end Number 3700 Water Loo R	oad			10f. Zip C		526			10g. Citizen of Unite			
	or Its	by	11. Maritel Stetus 1 □ Never Married 2 ■ Married 3 □ Widowed 4 □ Divorced	Armed Fe 1 Yes If Yes, Gi	2 No		Was Deceder If Yes, specify 1 ☐ Yes 2			gin? (Sp , Puerto	ecify Yes or No Rican, etc.)	Speci	ce - Americ eck, White, fy:		i,
121	c + 10	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12.	rade completed)	1-4or 5+)	(Give	dent's Usuel C kind of work DO NOT use Salesma	done retire	during most	of work	sing	16b. Kind of E			Agent
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	certificate be executed and ing physician and unding physician and case es the buriel-fransit	al Examiner	Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		udomo Due to (Yas or es e consec	Pheu quence of): neun	m	miti nia					Onset el	Between nd Deeth
	inet the death certificate ad by the ettending phys detached for use as the	Physician/Medical	Part II. Other significent conditions	d	<u> </u>	or es e consec		se giv	ven in Pert I.			tobecco use ci			
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Division	ital or Attending its after death. al Director: After led in by the fune	Certification:	3 Suicide 6 Could not be determined	286. PIECE	of Injury - At h ing, etc. (Specia	ome, ferm, str	eet, factory, o	ffice				(Street and Num wn, State)	ber or Rura	I Route N	lumber,
	within 24 hours after To the Funeral Dir. completely filled in	edicai	29a. Certifier 1	miner: On the b	best of my kno asis of examine ner stated.	owledge, deet etion end/or in	occurred et t vestigetion, In	he tir my c	me, dete end opinion, deet	d plece, th occur	end due to the red et the time.	ceuse(s) and m date end plece	enner es s , end due to	teted. the caus	se(s)
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			Dr. Julie A	completed caus				Fı	reder	ick	, Mar	yland	2067	78	
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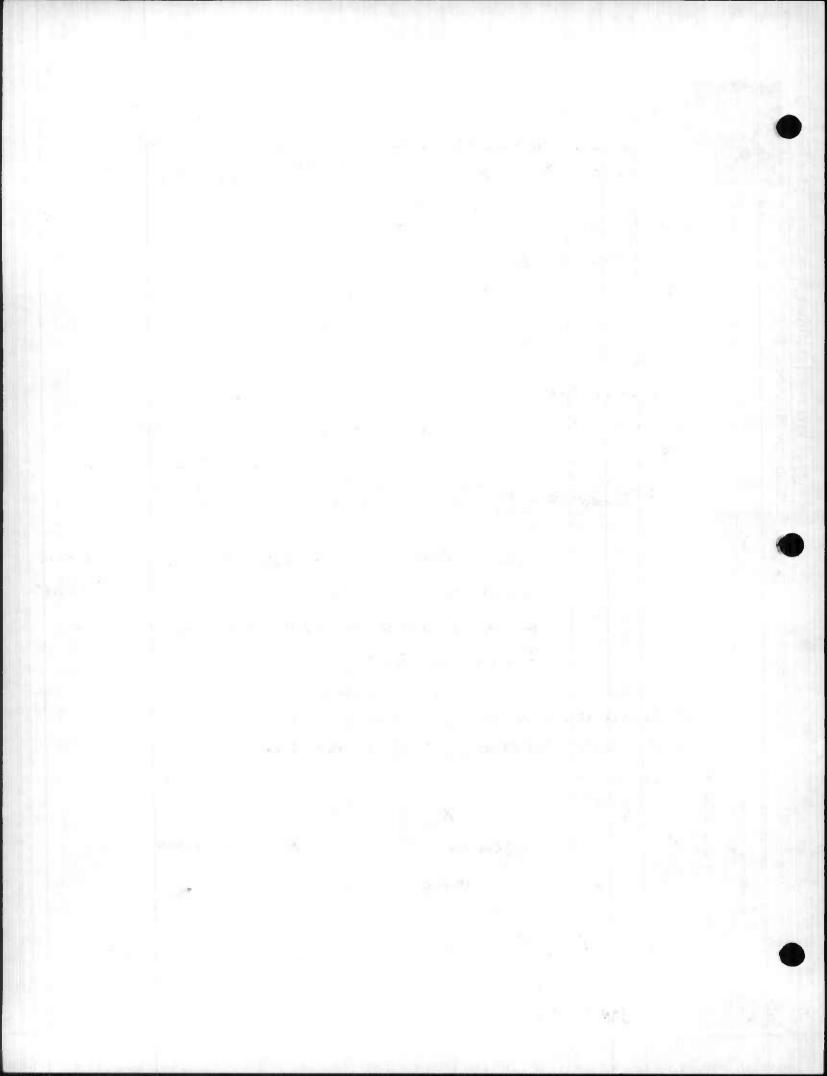
State of Maryland / Department of Health and Mental Hygiene 9 8 0 2 7 0 3

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Gary & Tonya Broseker/Parents 7105 Remwick Court, Glen Burnie, MD 21061 20a. Manded of Disposition 1 [Runial 2 Correctments 3 Removal room State 4 Denation 5 Detail 2 Detail 2 Detail 4 Denation 5 Denation 6 Tkad	0	William Todd Hawkins			Tonya I	Marie E	llis		
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Total Content of the Content of th	27 ls		Gary & Tonya Broseker/Par	ents					
10 CBurst 2 Coremation 3 CRemoval from State Springhill Managery Cardens 1/19/98 Hebron, MD 21. Signature of places Springhill Managery Cardens 1/19/98 Hebron, MD 22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Constant Rules List Gry one classe of constant Rules 1/19/98 Cheef Rules	Eetho	-		20b. Pla	ce of Disposition (Nama of				
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30. Name approaches of carson who completed cause of death (Item 23a) (Type, Print)	Funeral etely filled		(Unack only 2 Medical Examinar: On the bas	is of axaminatio	edga, daath occurred at tha tii n and/or invastigation, in my c	ma, data and place, pinion, daath occur	and dua to tha ca red at tha tima, da	usa(s) and mann ita end place, and	ar as stated. d dua to tha causa(s)
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30. Name any active of parson who complated causa of death (Item 3a) (Type, Print)	F 8		O //	13	AND 290. Licans	10201	25	u. wata signed (CG C
30. Name and address of cyrison who complated causa of death (Illem 33a) (Type, Print)	1		Jells a lo	2/,	MO D	1228		11/51	40
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State of Maryland / Department of Health and Mental Hygiene

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Social Security Number C. See 12		Memori	al Hospital	at East	on	Easto	n	Ta1	hot
TO THE PROPERTY OF THE PROPERT	Funeral		6. Sex 7.		(ev) if Under 1 Year	If Under 24 Hrs.			
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18. Mother's Name (First, Middle, Last) 19. Making Address (Street and Number of Plus House Number, City or Town, Steels, Zp Code)		15. Dece (Specify only hi	dent's Education thest grade completed)	10	ive kind of work done	during most of war	king	6b. Kind of Bus	iness/Industry
18. Mother's Name (First, Middle, Last) 19. Making Address (Street and Number of Plus House Number, City or Town, Steels, Zp Code)	Per Per Per Per Per Per Per Per Per Per	Elementery/Secondary (0-1	2) College (1-4	or 5+)	fe. DO NOT use retire	Pa)			
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Immediate Cause (Final disease or condition seasible) Immediate Cause (Final disease or condition) Immediate Caus	No. of the last	shock, or heart failure.	list only one cause on each	n line.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			,	Interval Betwee
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that infinited events or the Control of the Cont	Examiner	disease or condition		Due to (or as a cor	nsequence of):		CIATIO	JN	
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30. Nather and address of person who completed bauds of death (Item 23a) (Type Print)	E Fune Fune letely fi	(Check only 2 Medic	cel Examiner: On the basis	s of examination end/o	eath occurred at the ti r Investigation, in my o	me, date end plece opinion, death occu	, end due to the ce rred at the time, de	use(s) end man te end place, ar	ner as stated. Id due to the cause(s)
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30. National address of person who completed baude of death (Item 23a) (Type, Print) John Condit 463 Marvel Ct. Easton, md. 21601	CO TWIT	VY//						1 -0 11-	- W W
John Condit 403 Marvel CT. EASton, md 2/601	T oo	ALC	mas j	n po		11416		1-61	10
	wit To Coo	30. Name and address of pers	on who completed cause of	f death (Item 23a) (Ty	ne Print)				10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Month CHESTER **JOSEPH** FRANCIS 20 1998 Jan 1517 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth The Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) 11XM 2□ F Months Days 213-03-2671 Yrs. 90 July 4, 1907 Kansas Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Talbot St. Michaels 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 1208 Jefferson Ave. 21663 U.S.A. 12. Was Dacedent Ever In U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - American Indien, Black, White, atc. 1 Yas 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 Sunpapers Printer 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James J. Francis Anna Durant 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Wife Beulah E. Francis 1208 Jefferson Ave. St. Michaels, Maryland 21663 20e. Method of Disposition 1 □ Burial 2 🗷 Cremetion 3 □ Removal from State 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) Capitol Crematory Jan. 21, 1998 Dover, Delaware 21. Signetury of Funeral Service Licensee 22. Name end Address of Fecility Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663 deonuro 23a. Part1. Enter the diseesa, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or raspiretory arrast, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death Immediata Cause (Final disease or condition resulting in death) Ventricular Fibrillation 15 minutes hart unknown. Sequentiatly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events thet initiated events resulting in deeth) Lest Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of ceusa of death? 1 ☐ Yes 2 No 1 Yes 25. Was cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo

Physiclan /Medical Examiner

that the death certificate be executed

Box 68760

P.O.

Division of Vital Records.

Hospital or Attending Physicien:

To the

death.

this

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is eny injury or other treu

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

7 is marked other than "naturel", or Items 23a or 28a-f show treumstic event, the Medical Examiner must be notified at

Hygiana.

and Mental

Chester Francis

Baltimore, Maryland 21215-0020

physician and s the burial-transit attanding p signed by I should funeral

the

Physician/Medical Examiner ρ Completed Be Medical Certification: To within 24 hours after death To the Funerel Director: , completely filled in by the

27. Manner of Deeth

29a. Certifier

Neturel 2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and mannar stated.

28a. Dete of Injury (Month, Dey Yeer)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature end title of certifier Matthew Joseph Fischer MD

5 Pending

investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year) 1/20/98

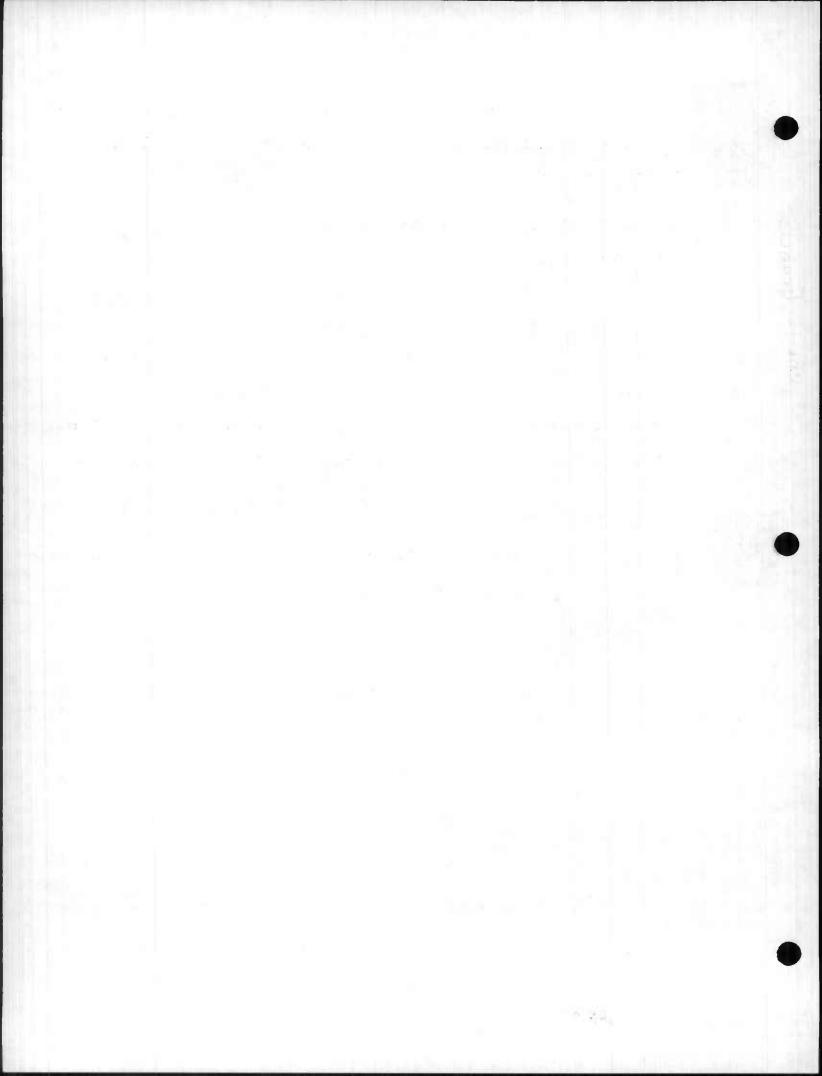
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Easton Dutchmans Lane

31. Dete filed (Month, Dey, Year)



State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 14 1998 ee CHERYL ANN FAGLIE 8:52 P /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Nov. 30, 194 Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Deys 264-96-0844 51 Director South Carolina Usual Residence of Decadent 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Directo Maryland Montgomery Germantown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 19375 Hottinger Circle 20874 Funeral United States death \ 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Heelth and Mental Hygiena. Important: If Item 27 is merked other than "natural", or ite any injury or other treumatic event, the Moulcal Examine sing. 1 Never Married 2 Married 1□ Yes 2□ No Baltimore, Maryland 21215-0020 à Specify: White 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) own home homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Luther Lafayette Ramsey Nancy Eileen Few 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Laura Ann McMurray (daughter) 19375 Hottinger Circle, Germantown, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Buriel 2 Cremation 3 Removel from State 4 Donetlon 5 Other (Specify) U.S.U.H.S. 1-16-98 Bethesda, Maryland 22. Neme end Address of Fecility
Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 21. Signeture of Funeral Service Licensee anol a 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) CEREBRAL HEMORRHAGE Examiner Due to (or es a consequence of): Physician/Medical Examiner attending physician end for use es the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury Due to (or es e consequence of): Box 68760. thet Initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were eutopsy findings eveileble prior to completion of cause -of deeth? Completed 24e. Wes en eutopsy performed' paga 2 s has 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: 1 ⅓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No this funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Death Certification: 28d. Describe how injury occurred Injury et Work? After 5 Pending investigation or Attending 1 Naturel A 24 hours after death.

A 54 hours after death.

A 6 Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) and menner steted. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi Medicai (Check only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Dey, Year) M.D. JAN. 15, 1998 MD-0000028855 (TN)

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

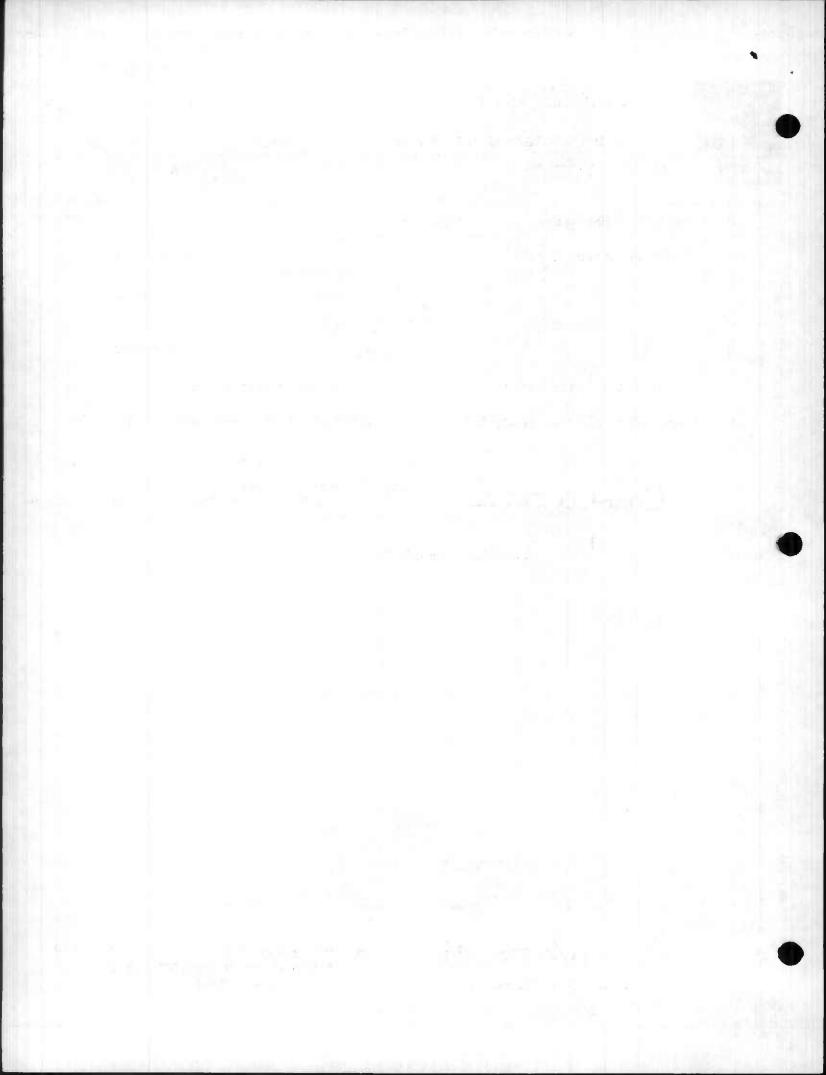
State Registrar 30. Nerpe end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

EASTONE, LT, MC, USN

32. Pegistrer's Signeture

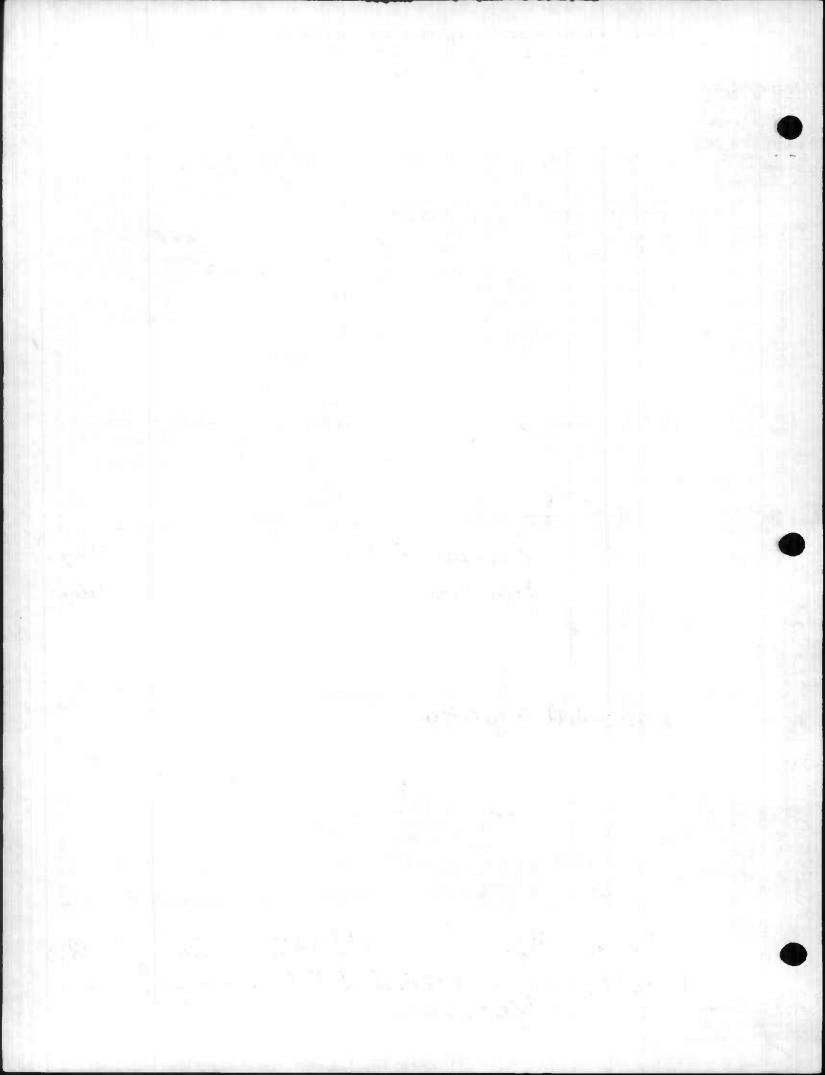
Randelle

A.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

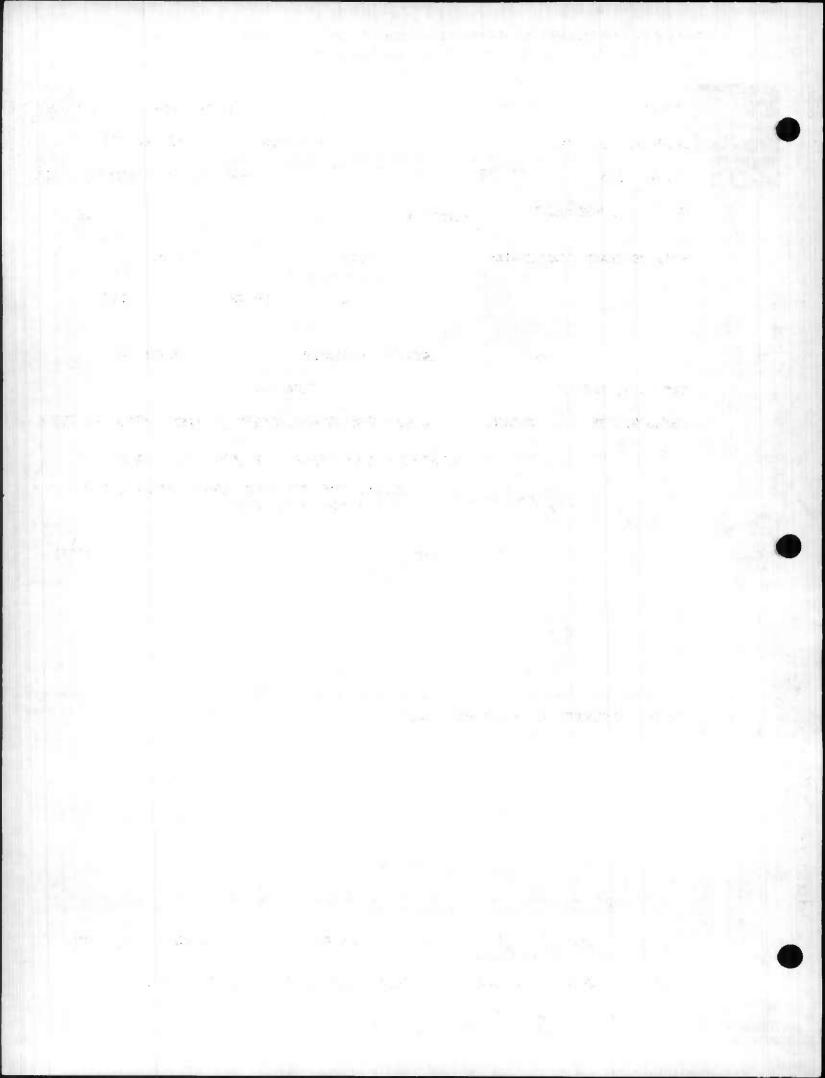
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	rian	1. Decedent's Name (First, Middle, La								ete of Deeth	Dey	Yeer	3. Time of Deeth
/Med		Alfred Fish							Ja	nuary	15,	1998	7:30pm
Exami	iner	4e. Fecility Neme (If not institution, given Suburban Hospi		n <i>ber)</i>				4b. City, Town,		of Deeth	4c. County		
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Funeral Director	_		Sex 1 X M 2 □ F	7. Age (In yrs. 8 9	Yrs.	Months			Vin. 0.6	ete of Birth fonth, Dey, Y t • 1 ,	(ear)	9. Birthpl Coun. Isra	lace (State or Foreig
		Usuel Residence of Decedent		- 0,		L	1		00	,	1300	191	161
yland		10a. Stete 10b. County		10c. Cit	y, Town or Lo	cation						10	0d. Inside City Limits
a-f si	tor	Maryland Montg	gomery	Ro	ckvil.	1e							1⊠Yes 2□No
th with the Marylan 23a or 28a-f show	ire	10e. Street end Number				10f. Z	ip Code			10g	. Citizen of \	Whet Coun	try?
23a	la	6121 Montrose	Rd.			2	085	2		U	.S.A.		
teme teme	Funeral Director	11. Marital Status	Armed Fo	edent Ever in U	,S. 13.	Was Dece	edent of H	lispenic Origin' en, Mexicen, P	? (Specify Yuerto Ricen,	es or No-		e - America ck, White, o	
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Marial hygieran. Important: if item 27 is marked other than "setural," or items 23a or 28a-f show any injury or other treumatic event, the Maryland Enamine must be notified as angles.	by F	Never Married 2 Married 3 Widowed 4 Divorced	1 Tes If Yes, Giv	/e			2 DENO	Specify:			Specify		
hour tural	8 D	15. Decedent's E	Year or Da	ates:	16e. Dece	dont's Lle	uel Occur	ation		1.0		AA TI 7	
215. Iin 72	Be Completed	(Specify only highest gra	ade com <i>pleted)</i>		(Give	kind of w	vork done use retire	during most of d)	working	16	ib. Kind of B	usiness/ind	lustry
212 3 with liena.	Eo	Elementary/Secondary (0-12)	College (1	-4or 5+)				Broke		S	elf-I	Emplo	nved
other of the	S S	17. Father's Name (First, Middle, Last)					18. Mother's				_	
/lan	To	Unknown						Unkn	own				
Baltimore, Maryland 21215-0020 semit. Peges 1 and 2 should be filed within 72 hours aft Department of Health and Mental hygiena. Important: if flem 27 is marked other than "natural," or my injury or other treumatic event, the Medical Enam purge.		19e. Informant's Name/Relationship (Type, Print)		19b. Meilir	ng Addres	ss (Street	end Number o	r Rural Rout	te Number, C	City or Town,	Stete, Zip	Code)
and and a salth n 27 incr tree		Rudolph Hegmon	/POA					ton Ct	. Anı	nanda	le, VA	220	003
Ore les 1 of He filen		20e. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐	Hamourai team	0	Plece of Dispo semetery, crer	natory or	other plea	ce)	Det		c. Location -		
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Ball Ball Depart Import		21. Signature of Funeral Second Con	500		22	2. Neme e	end Addre	ss of Facility					
у ш ховая		Stund	Alla	Vac	- 28	347	Wils	son Bl	vd.	Arlin	gton.	VA	22201
	П	Pert1. Enter the disease, or com shock or heart failure. List only	plications that co	eused the deetl	h. Do not ent	er the mo	de of dyir	ng, such es cer	diec or resp	lretory errest	l,		Approximete Intervel Between
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/Medical Examiner	п	Imme La Cause Emil disease or Lion resulting In death)	a. Ites	pivato	sy F	auli	m						1 days
	5		0	Due to (o	or as e consec	quence of):						1 days
nsit nsit	듵		b. Pne						-			- 5	days
), exect and n and	Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury		Due to (o	r es e conseq	uence of)):					i	/
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x 68760 certificete be ding physicia se as the bur	Medical	resulting in deeth) Lest		D00 10 (0)	es e conseq	uence on						1	
OX OX OX ondin			d	-									
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The ata	Con									1 🗆 Yes	20 No	1	Yes 2□ No
Vital Indicion: The certificate	Be	25. Wes cese referred to medical examiner?						28. Plece of	Death (Che	ck only one)			
- 0 -	10	1 Yes 2 No		•	ER/Outpetien	-		4 LI Nursin		Residence)
this se direction		27. Manner of Deeth 1 □ Naturel 5 □ Pending		h, Dey Year)	28b. Time of Injury	М	28c. Injur Wor		28d. D	escribe how	injury occur	red	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Netural 5 Accident	_	(Mon	of Injury th, Day Year)					28d. Describe h	now injury occur	rred	
	6 Could not be determined	200. Place	of Injury - At ing, etc. (Spec	home, farm,	street, fac	ctory, office		28f. Location (S City or Tov	Street and Numb vn, State)	ber or Rural Rou	te Number,
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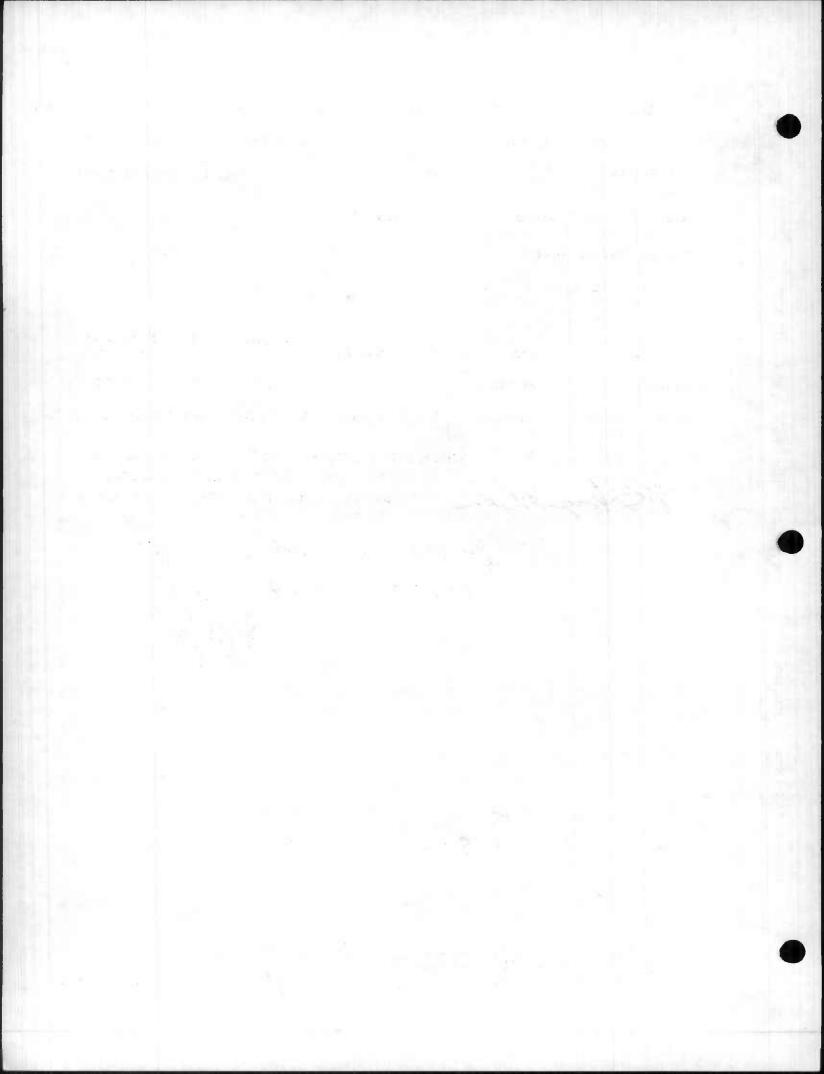
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month JANUARY 1, 1998 1:45 P.M. FLETCHER, ELLWOOD LEREA /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ANNE ARUNDEL GLEN BURNIE NORTH ARUNDEL HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 □ F Deys 85 Yrs. Director 219-22-4481 MAR. 26, 1912 MARYLAND Usuel Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow must be notified at GLEN BURNIE 1 TYes 2 No Director ANNE ARUNDEL MARYLAND 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? 0 U.S.A. 21061 itams 23a 500 W. FURNACE BRANCH ROAD Funeral filed within 72 hours efter death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. traumatic event, the Medical Examiner 1 Never Married 2 Married 21215-0020 ò 1 Yes 2√ No Specify: Specify: WHITE by 3 Widowed 4 Divorced "natural", Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) LIEUTENANT 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest g. rede completed) BALTIMORE CITY ie markad other than Elementery/Secondery (0-12) College (1-4or 5+) FIRE FIGHTER 12 FIRE DEPARTMENT Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Pages 1 end 2 should be BERTIE FLETCHER BONDURA 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 500 W. FURNACE BRANCH ROAD, GLEN BURNIE, MD. 21061 nt of Health e : if item 27 ie or other tra SOPHIA FLETCHER (WIFE) Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1/6/98 1 ☐ Burial 2 【Cremation 3 ☐ Removel from State permit. Page Department of Important: if any Injury or once. BELTSVILLE, MD. CHESAPEAKE CREMATORY, INC. 4 Donation 5 Other (Specify) 21. Signature of Funeral Sep 22. Name end Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, M.D 21061 sease of complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, ure. List only one ceuse on each line. Approximete intervei Betw Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In deeth) **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest pue the buriel-tran Box 68760, Physician/Medical Due to (or es e consequence of) P.0. the t Pert ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? rithis certificate has been signed by that director, page 2 should be detect 1 | Yes 2 1 No 3 | Probably 4 | Unknown Records, by 24b. Were eutopsy findings eveilable prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 HNo 1 Yes 2 No Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 1 | Yes 2 | 1 No in by the funeral 27. Manner of Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred After 5 Pending investigation 1 Natural death. 1 Yes 2 100 (AMP FELL DOWN STAIRS 2 Accident or Attend efter death Director: 3 Suicide 6 Could not be Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Mospital c within 24 hours el To the Funerel D 1 Detritying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end manner stated. 29a. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30, Name and address of person who com Hay, Slen Burnie, MAD 21061 Kosg-フょ 31. Date filed (Month, Dey, Year)

JAN 2.9 32. Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Deeth **Physician** Month Dev anuary 8,1998 4c. County of Deeth 0510 /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Name (If not institution, give street end number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number Age (In yrs. lest birthday) 8. Date of Birth, Day, 9. Birthplece (State or Foreign Country) **Funeral** Devs 219-18-4259 Usual Residence of Decedent Months Hours Director the Maryland 10e. Stete 10b. County 10c. City, Town or Location d other than "netural", or items 23a or 28a-f show event, the Medical Expanser must be notified at 10d. Inside City Limits Yes 2 No Director Wicomico 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 1 21865 Funeral 11. Marital Stetus Wes Decedent Ever In U.S. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Bleck, White, etc. 72 hours efter 1 Never Married 2 Married 1 ☐ Yes Specify þ 3 Widowed 4 □ Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Şeçondary (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) is marked other 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be Health and Mentel (juter muth (0//ex 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Fisher Tyaskin, MD 21865 22110 mportant: If item 27 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece, Dete 20c. Location - City or Town, Stete Department of Burial 2 Cremation 3 Removel from State 0 Heloon 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licensee Name and Address of Fecility 112146 Md Nat caused the death. Do not enter the mode of dying, such as cardiac or respiretory on each line. 23a. Pert1. Enter the disease, or complication shock, or heert failure. List only one cause Approximete Intervel Betw Onset end Deeth **Physician** /Medicai Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): physician the Due to (or es e consequence of): 98 ettending | the e Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Unknown 1 ☐ Yes 2 No à 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Be Completed 24e. Wes en eutopsy performed? peed ete hes l 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred

The law requires that the death certificete be executed Records, P.O. Box 68760. Division of Vital Hospital or Attending Physicien: 24 hours efter death.
Funerel Director: After this certifice stelly filled in by the funerel director, t To the Hospital or within 24 hours eff To the Funerel Dicompletely filled in

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Date of tnjury (Month, Dey Year) 28c. Injury et Work? 5 Pending investigation Neturel 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

who completed cause of deeth (Item 23a) (Type, Print)

,560 Rivers Dr. B101 Wieland Salisbury Md 2/801 re 1 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate of	f Death	Re	eg. No.	02/11
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Examir	ner	4e. Fecility Neme (If not institution,	give street and num	iber)			4b. City, Town, or L	ocation of Death	4c. County	of Death
		Genesis Elder					Easto			lbot
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Sta		31. Date filed (Month, Dey, Year)	32 Re	gistrer's Signe	ature		01001	DWNTRP	E. MA	M.D.

Registrar

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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month JANUARY 14 1998 ocation of Deeth 4c. County of Deeth GALES 13:05 JOSEPH 1998 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 24 Hrs. 8. De Hours Min. (M MONTGOMERY 8. Dete of Birth (Month, Dey, Year) Nov. 23, 1921 Birthplace (Stete or Foreign Country) Months Deys 1 M 2□ F 577-16-3312 76 Wash. DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes ATNo Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2001 Linden Lane 20910 USA 14. Raca - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1X Yes 2 No If Yes, Give Yeer or Detes:1942-1946 1X Never Merried 2 ☐ Married White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 US Government Maintenance Engineer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Timonthy W. Gales Alyce Cozzens 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) / sister Patricia Lowder 2001 Linden Lane Silver Spring MAryland 20910 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State ₩Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Arlington National Cem. 01/28/98 Arlington Virginia 21. Signature of Peneral Service Licenses 22. Name end Address of Fecility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring MD 20904 23a. Part1. Enter the disease, or complications of caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause or each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting In death) e. Metastatie squamous elle taged oguamtus cell Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Des 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

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Box 68760

P.O.

Division of Vital Records,

al or Attending Physician: T s efter death. Il Director: After this certificat ed in by the funeral director, p

• Funeral Hospital

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Certification: To

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28a-f show

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7 is marked other then "naturel", or Items 23a or 28a-f shor treumstic event, the Medical Examiner i wat be not liked at

permit. Pages 1 and 2 should be filed within. Department of Heelth and Mental Hygiene. Important: If Itam 27 Is marked other then any Injury or other treumstic event

the Marylenc

Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in deeth) Lest Physician/Medicai by Completed Be

1 Yes 2 No

1 TYPS 2 No

chronides 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 2□ No 1 ☐ Yes 2 ☐ ER/Outpatient 27. Menne of Deeth 28d. Describe how injury occurred 5 Pending Investigation

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28e. Dete of Injury (Month, Day Year)

28c. Injury et Work?

1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

1 Naturel

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or Investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) and menner steted.

29b. Signature end title of certifier

6 Could not be determined

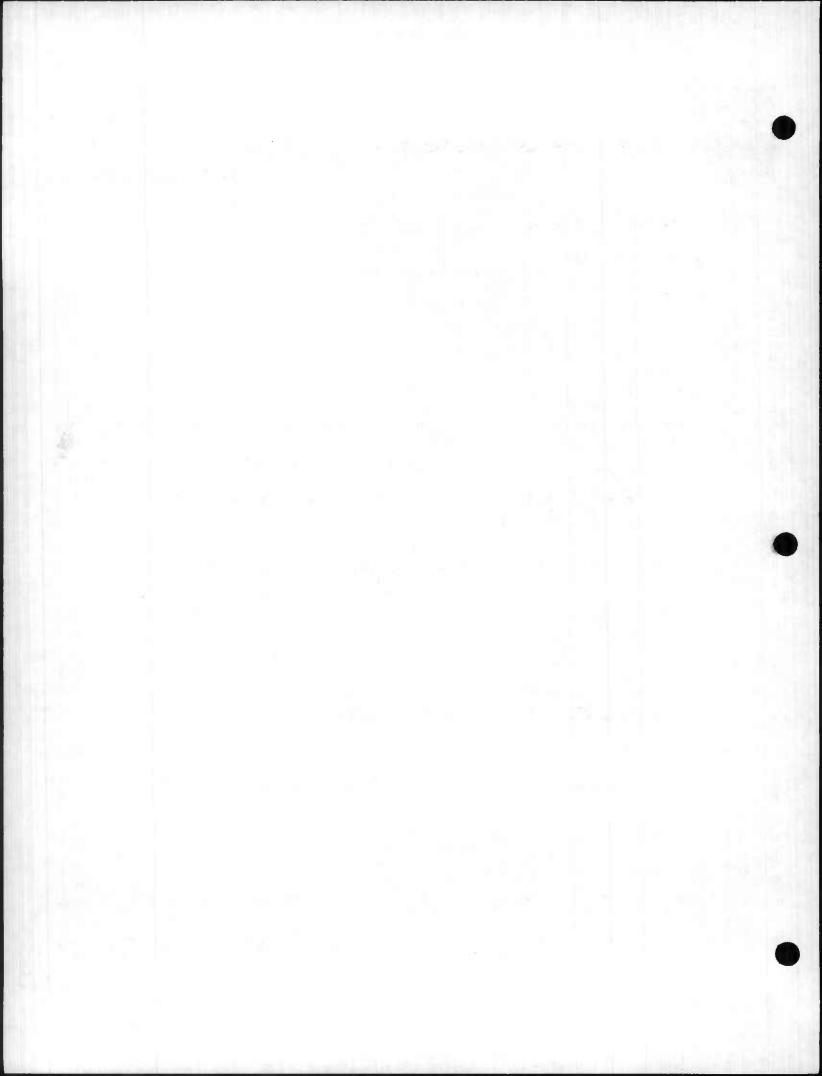
29c. License number

30. Name end eddress of person who completed cause of deeth (Item 23e) Type, Print)

31. Date filed (Month, Day, Year)

32. Registrer's Signeture Alia Varidson

Registrar



State of Maryland / Department of Health and Mental Hygiene

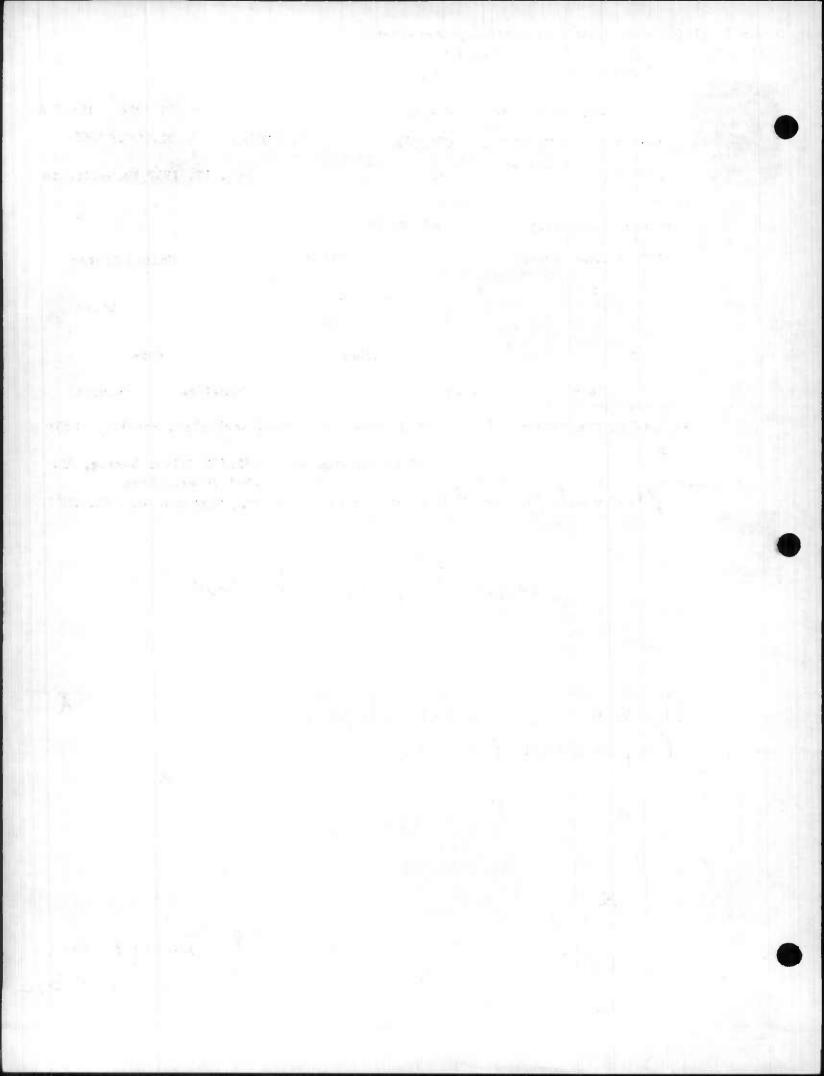
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 21, 1998 S. Barbara Gellert 2:50 PM January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 4108 Dresden Street Kensington If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2XF Yrs 285-36-4078 58 January 17, 1940 Pennsylvania Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylai Depertment of Heatib and Mental Hygiene. Important: if Item 27 is marked other than "netural", or items 23s or 28s-1 show any Injury or other traumatic event, its wandest Examine, must be notified as nay injury or other traumatic event, its wandest Examine. 1 Yes 2 No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4108 Dresden Street 20895 United States Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ρ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Psychologist Private Practice 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Harry Smith Ann Sas 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4108 Dresden Street, Kensington, Maryland Martin Gellert (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1-22-98 Beltsville, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) 7 months Brain Tumor - glioblastoma Examiner Due to (or as a consequence of) Examiner sician end buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or as a consequence of) Box 68760. physician the burie certificate be Physician/Medical Due to (or as a consequence of): 80 attending use signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Records. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed peen hes 1 Yes 2 No 1 Yes 2 No certificate Division of Vital Be 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1º 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? i or Attending F efter death. I Director: After 1 🖾 Natural 5 Pending investigation 1 Yes 2 No 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours en To the Funeral Discompletely filled in edicai Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated. 29a. Certifier 2 Madicat Examiner: On the basis of examination and/or invegand manner stated. ation, In my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) 29b. Signatura title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD000003820 January 21, 1998 30. Name and address of person who comp se of death (Item 23a) (Type, Print) Allen M. Mondzac, M.D., 2141 K Street, NW, Suite 707, Washington, DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Luta Savidson 2 3 1999 JAN Registrar



State of Maryland / Department of Health and Mental Hygiene 8 027 | 5

					Cert	tificate of	Death		Reg. No.	U	2/10
Dhusia	ion	1. Decedent's Name (First, Mic	idle, Last)	1-1-1-				2. Date of De		Year	3. Time of Death
Physic /Medi			garet An		rth			Januar	y 19, 1		10:15 AM
Exami	ner	4a. Facility Name (If not institut						or Location of Daat			EDV
N.B.		SHADY GROVE				M I Index 1 Vees	ROCKV			TGOM	
Funeral Director		5. Social Security Number 578-38-8098 Usual Residence of Decedent	6. Sax 1 M 2 F	7. Age (In yrs. last	Yrs.	Months Days		in. (Month, De	y, Year)	Cour	piaca (Stete or Foreign ntry) sylvania
show of all		10a. State 10b. Cour	ity	10c. City, T	own or Loc	ation				1	10d. inalde City Limits
death with the Marylend ms 23e or 28e-f show crivet be notified at	to	Maryland Mont	gomerv	Ro	ckvil	1e					1 ☑ Yes 2 ☐ No
or 28a-f	Funeral Director	10e. Street and Number	gomery			10f. Zip Coda			10g. Citizen of	What Cou	ntry?
th wit	a D	13203 Ardenne	s Avenue			20	851		Unit	ed St	ates
tar dea	ner	11. Marital Status	12. Was Deced	dent Ever in U,S.	13. W	as Decedant of	Hispanic Orlgin?	(Specify Yes or No arto Rican, etc.)		ce - Amaric	can Indian,
0 5 5 6	by	1 Nevar Married 21 M 3 Widowed 4 Divorce	arried 1 Yes	2 🔯 No		☐ Yes 2 No		arto riican, etc.)	Specif		hite
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Mal 12 st h end r is n		19e. Informant's Name/Relatio						Rural Route Numb			
Baltimore, N		Richard C. Gia	rth/Husband		3203	Ardenne	s Avenue	Rockvi Date	11e, Ma		
Baltimore, emit. Pages 1 e permit. Pages 1 e permitent of He moortant: If Item my injury or other more.		1 ⊠ Buriai 2 ☐ Cremation		tata	etery, crema	ition (Name of atory or other pla					
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Balti permit. Departri mporta my inju	-	21. Signature of Funaral Sarvio	Se Licensee	00	22.	Name and Addr	ass of Facility	DeVol Fur	neral Ho	me	
		Much	JO CO	ewal				Dr., Gai		rg, M	D. 20877
- 1		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that ca st only one cause on ea	used tha death. [ch line.	Do not enter	the mode of dy	ing, such as card	iac or raspiratory a	rrest,	i	Approximate Interval Between Onsat and Death
Physician /Medical	1	Immediate Cause (Final		0 - 0	1. 0						Crisal and Death
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68 tifica ig ph es th	led	resulting in death) Last		01010 (0.00		u					
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. 5 . 5	Physician/	Part II. Other significant condi	tions contributing to dea	th but not resultin	g in the und	terlying causa gi	iven In Part I.	23b. Dld	tobacco uae co	ntributa t	o the cause of death?
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Records, P.O. ha law requires thet the a has been signed by th aga 2 should be detache		Vocain	Lvy 7	- 6.11	1	V			an autopsy	24b. W	ere autopsy findings
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Division Lat or Attending Is efter death. Lat Director: After ed in by the fune	Certification:	4 Homicide dete	mined 286. Place of	of Injury - At home g, etc. <i>(Specify)</i>	, farm, stree	et, factory, office		28f. Location (City or To		er or Rura	al Routa Number,
Division of Vital Re To the Hospital or Attending Physician: Tha I within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a, Certifier (Check only one) Certify	ring Physician: To the base Examiner: On the base and manner	ils of examination	dge, death o and/or inve	occurred at the ti estigation, in my	ime, dete end ple opinion, death oc	ce, end due to the curred at the time,	cause(s) and m date and place,	enner es s end due t	tated. the ceuse(s)
To th Withir To th	M	29b. Signature and title of dertif	ier -			29c. Licen	se number	10	29d. Date signe	d (Month,	Day, Year)
16)	en	- mi		an.	U504	67	Januar	4 19	(1998)
		30. Name and address of perso	n who completed cause	of death (Item) 22	(Type, P	gint)	11116	0,105	. Cealer	1111	(4.0
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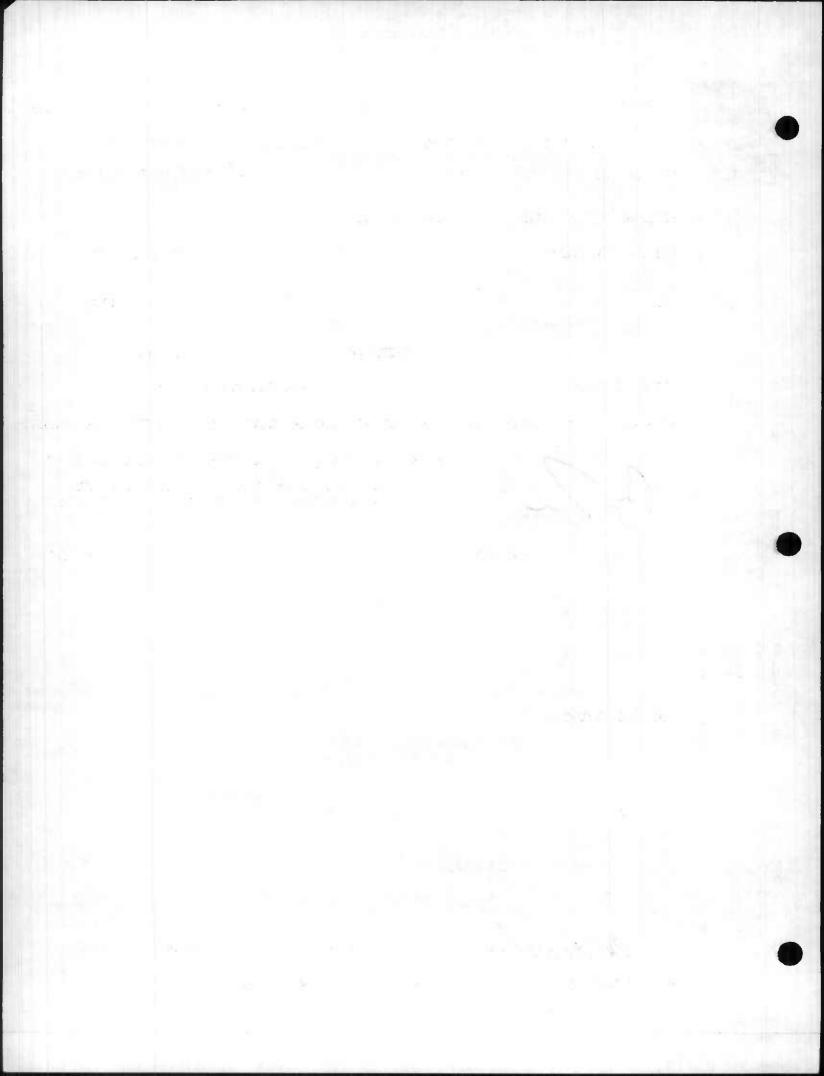
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes

	-	Decedent's Name (First, Middle, Las	<i>4</i>)		Certifica	ate of	Death	2. Dete of De	Reg. No.	UC	3. Tima of Deeth
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72 hours 'natural', edical Ex	pete	15. Decedent's Ed (Specify only highest gred		166	. Decedent's U	sual Occu	pation during most of wo	rkina	16b. Kind of B	usiness/Indust	try
swithin plane. Than	Completed	Elamantary/Secondary (0-12)	College (1-4or 5	+)	lifa. DO NOT	Tusa ratire	ed)	Ning			
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d be d	Be	LOUIS LEHRMAN						ne (First, Middle, A FRIED	Maidan Suman	10)	
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nit. Pacantment cortant: injury in		4 Donation 5 Other (Specify)	MENO	RAH GAR			1/21/98	FT. LA	UDERDA	LE, FL
permit. Page Department of Important. If any injury or once.		21. Signature of Funerel Service License	100		DANZI	NASKY	ess of Fecility -GOLDBER VILLE PIK				NC. AND 20852
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tel or Attending rs after death. al Director: After led in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicida determined	28e. Place of Injubulding, ato	ry - At home, for a second control of the control o	erm, street, fact	ory, office		28f. Location (City or To	Street end Numb vn, State)	er or Rural Ro	oute Number,
To the Hospital or within 24 hours afte To the Funeral Dir completaly filled in	edicai	29a. Certifiar (Check only one) 1 ☐ Certifying Phy 2 ☐ Medicel Exami	sician: To the best of iner: On the bests of and menner sta	examination er	a, daath occurre nd/or invastigati	ed et the ti	me, dete end plece opinion, daath occu	e, end due to the irred at tha tima,	ceusa(s) and ma date end place,	annar as state end due to the	d. e ceuse(s)
To the Within 2 To the	M	29b. Signature end title of certifier	//		2	29c. Licen	se number		29d. Date signe	d (Month, Dey	/, Year)
3		BALKON	elle			D098	34	J	ANUARY	19, 199	98
		30. Name end eddrass of person who comes BARRY ROSENBAUM -				- KEN	SINGTON	MARYI.AN	T) 20895		
		Transce Trop Daliberati	O, 20 1111			TATEL			~ ~~~		

DHMH 16 Rev 6/95



UNK. 98-019 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. wlc State of Maryland / Department of Health and Mental Hygiene 98-0269-03; Certificate of Death RASIL GRIMES 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Dey **Physician** E. BASIL GRIMES 17, 1998 4c. County of Deeth 4b. City, Town, or Location of Deeth 513p /Medical 4e Fecility Neme (If not institution, give street end number) Examiner GAITHERS BUTTLE STATE OF BIRTH (Month, Day, Year)
The D. 8, 1970 RIGGS & Rt 108 MONTGOMERY If Under 1 Year 9. Birthplece (Stete or Foreign Country)
Maryland 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** Months Deys 11XM 2□ F 27 Yrs. Director 577-96-9053 Usuel Residence of Decedent the Merylend 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ral', or items 23s or 28s-f shore Examines must be notified at 1 Yes 2 XNo MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number with 눕 21 Baileys Court 20906 U.S.A. d 2 should be filed within 72 hours effer death vin and Mentel Hygiene.
7 Is marked other than "natural", or Items 23, traumatic event, Ite Medical Examples man Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2% No If Yes, Give Yeer or Detes: 14. Raca - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Status 1X Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 yr Car Detailing Auto Co. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Basil Burriss Josephine Carroll permit. Pages 1 and 2 sh Department of Heelth and Important: If Item 27 is m any injury or other traum pace. 19a. Intermant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Josephine Staton (Mother) 2834 Ω St., SE #102, Washington, DC 20020 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location · City or Town, State 20e. Method of Disposition Date 1 Burial 2 Cremation 3 Removel from State Ash Memorial Cem . 1/24/98 Sandy Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Fecility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 ease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Pert1. Enter the dr shock, or heart for Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner as a consequence of): Examiner ettending physician end for use es the burial-trensit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequença ot): Box 68760. Physician/Medical that initiated events resulting in death) Lest Due to (or es e consequence of): ed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were eutopsy tindings evaileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? The law certificate hes b 1 Yes 2 No 1 Peyes 2□ No or Attending Physician: 25. Was case reterred to medicel exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 \square Nursing Home 5 \square Residence 6 \square her (Specify) SCENE XXYes 2 No 2 this 28e. Dete of Injury (Month, Dey Year) funerai 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? so reliebs Certification: 5 Pending investigation 1 Natural agosty or 1 Yes 2 No deeth. oy the f 2 Accident -17.98 1700 Location (Street end Number or City or Town, Stete) 6 Could not be 28e. Placa of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 - Homicide effer Dir lda To the Hospital o within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) end manner as stated.

**Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

cause of death (Item 23a) (Type, Print)

Davidson gandage

Registrar's Signeture

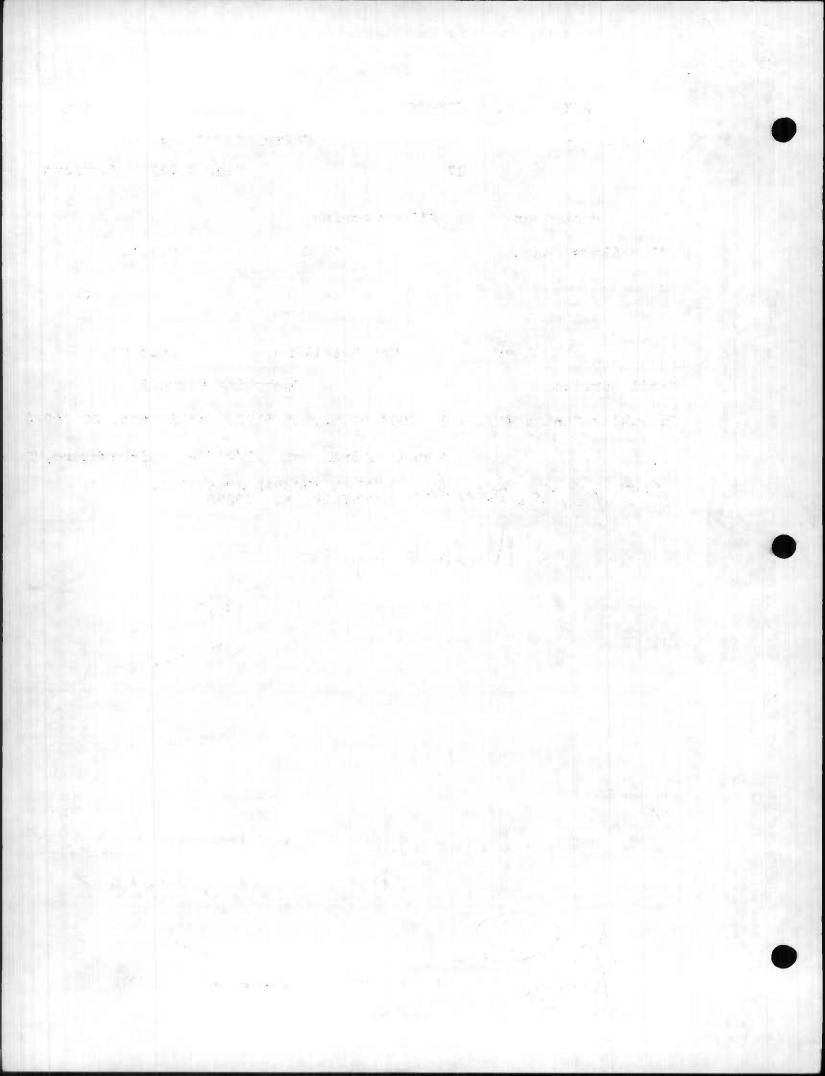
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State Registrar 30. Name and add

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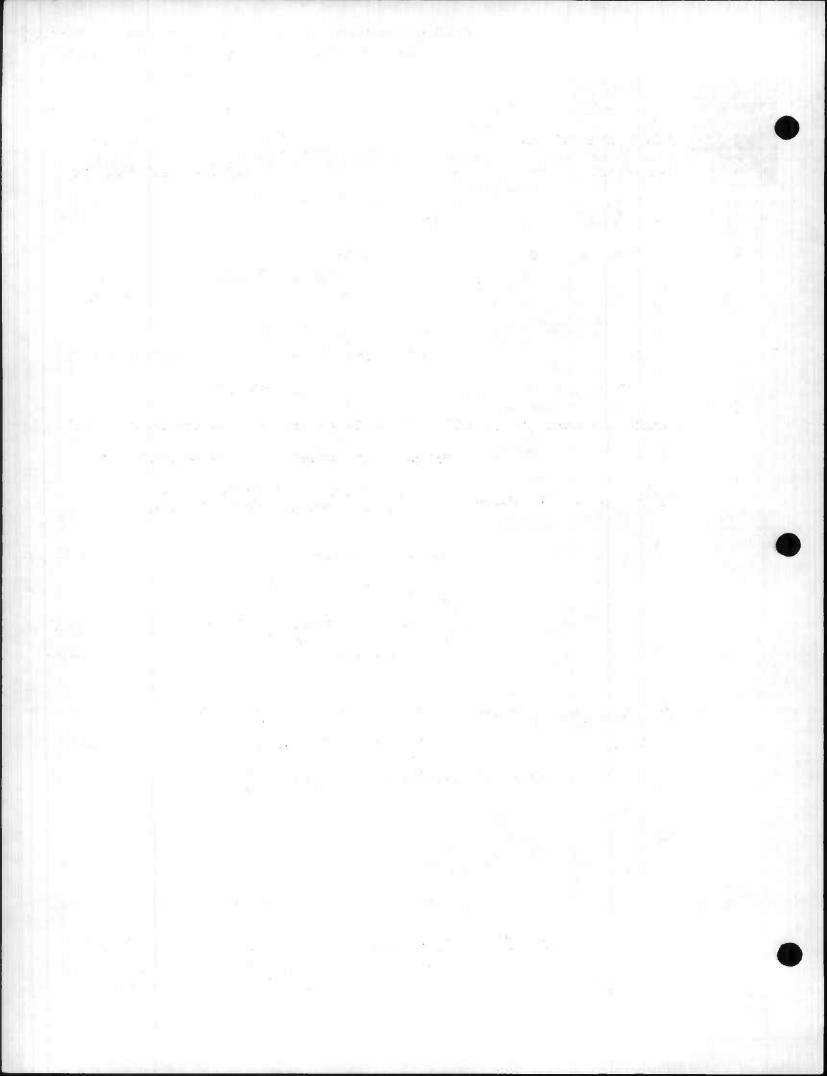
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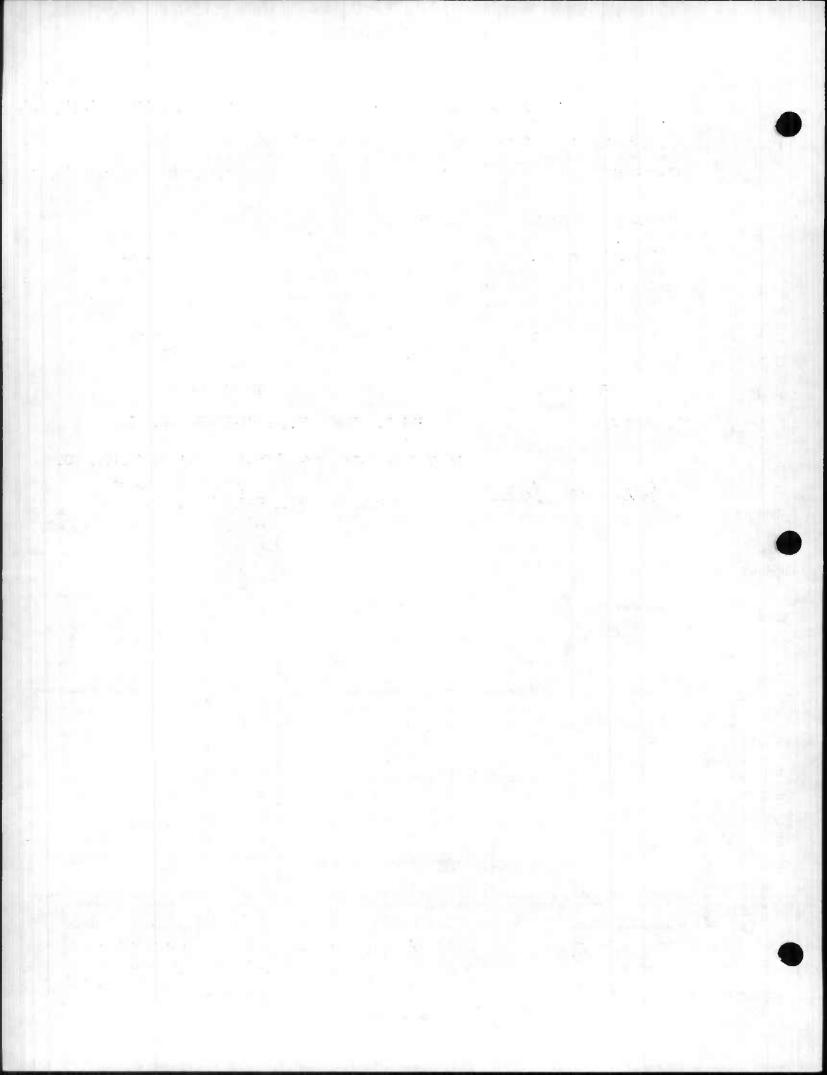
State of Maryland / Department of Health and Mental Hygiene o

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with with	Funeral Director	10e. Street end Number 1031 BOUCHER	AVENUE		10f. Zip Code 21403		10	Og. Citizen of WI	net Country? US		
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State of Maryland / Department of Health and Mental Hygiene

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SKIELES FUNCHA HOME 210 W. MAIN ST. EMMISSURG, MD. 21727 Physician (Medical Examiner) Physician (Medical Examiner) Sequentially list conditions the aused the death. Do not enter the mode of dying, such as cardiac or respiratory areas. Inferiore Between Order and Death (Medical Examiner) Due to (or as a consequence of): Due to (or as a con	0	0 00 0				Removel from Ste		emetery, creme	itory or other ple			20c. Location	- City or To	wn, Slele			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month ALVIN Yreen John January 4a. Fecility Name (If not institution, give street end number 4b. City, Town, or Location of Deeth 4c. County of Death UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE CITY If Under 1 If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) 9. Birthplece (State Country) 10/14/1923 MARYLAND 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign 1 € M 2 □ F 220-16-0867 74 Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 102 TIMBER RIDGE DR., APT. 309 21157 USA. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 ₩idowed 4 Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEAT TREAT OPERATOR MANUFACTURING 9 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JOHN MORRIS GREEN HAZEL MATHIAS 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 801 MOUNTAIN VIEW DR., WESTMINSTER, MD.21157 GAIL A. NOLTE - DAUGHTER 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State TRINITY LUTHERAN CEM. 1/23/98 WESTMINSTER, MD. Donetion 5 Other (Specify) 22. Name and Address of Fecility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Betw Onset and Deeth Immediate Ceuse (Final disease or condition resulting in death)

Physician /Medical Examiner

physician end s the burial-trans

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signed by the a d be detached f

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funeral

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Mospital or Attending Physician:
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 Funeral Director: Affer this certifica

To the Hospital or A within 24 hours effer To the Funeral Dire complataly filled in b

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy, Important: If flem 27 is marked othe shy injury or other traumatic event, 9008.

Funeral

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filed within 72 hours after death

altimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed Be 2 Certification:

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 PNo 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Yeer) 27. Manger of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Naturai 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide 29a. Certifier 1 🗹 Certifying Phyeicien: To the best of my knowledge, death occurred at the time, dete end placa, end due to the ceuse(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the ceuse(s) end menner stated.

29c. License number

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Sonuthan A. Turoff, M.D., Dept. of Newslogy; 22 S. Weene H.; Buffmane, Ms-212d

Grathon A Turollon-0-, Resident AU4176435

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29d. Dete signed (Month, Dey, Yeer)

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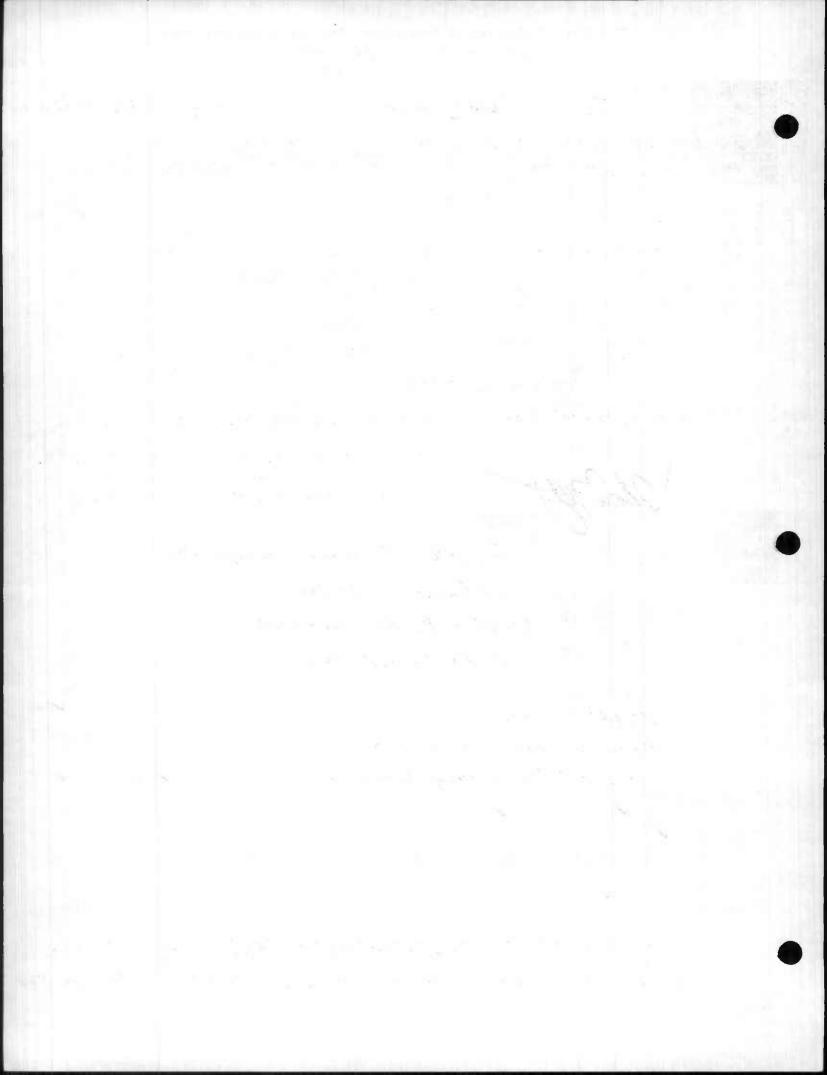
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29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Yeer)

JAN 2 1 1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0345 GERALDYN J. GIRARD JANUANY 11,1998 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SALISBURY WIG If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Yeer) PENINSULA REGIONAL MEDICAL CENTER WICOMICO 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 M F Months Days Yrs. Director 69 144-20-4679 11/20/28 New Jersey Usual Residence of Deceden 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner insist to notified at Md. Worcester 1 ☐ Yes 2√ No Director Berlin 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 11331 Gum Point RD 21811 US Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2XC No If Yes, Give Year or Dates: Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Haeith and Mental Hygiena. Important: If Itam 27 is marked other than any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 5+ US Govt. Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Horace H. Girard Evelyn Anderson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1155 Earl Ave., Schenectady, N.Y. 12309
ca of Disposition (Name of Date 20c. Location - City or Town, Stete Moira J. Coons (cousin) 20b. Placa of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 1 ☐ Burial 2 Cremetion 3 ☐ Removal from Stete Cape Henlopen Crematory I-16-98 Frankford, Delaware 5 ☐ Other (Specify) 21. Signatu Funeral Sew 22. Neme end Address of Facility THE BURBAGE FUNERAL HOME, 108 William St., Berlin, Md. 21811 are complications that caused the death. Do not enter the mode of dying, such as cardiec or respired by errest, Onset and Death Physician /Medical Immediate Ceuse (Final metastatic Carcinona of Bladder 14000 disease or condition resulting in death) Examiner -transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or as e consequence of): Physician/Medical the Due to (or es a consequence of): for u Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by t 3 Strobably 4 Unknown 1 ☐ Yes 2 ☐ No Chronic Osstruction Pulmorary 24b. Were autopsy findings avellable prior to Completed 24a. Was en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, 25. Was case referred to medical Be 26. Piece of Death (Check only one) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end pleca, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Jan. 11. 1998 1.0. 030690 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Carroll ST. Solisbury, MD 21801 11,2. James E. Martin 145 E. 31. Date filed (Month, Dey, Year) -32. Registrar's Signature Julia Davidson-Randalle State

Registrar

JAN 1 5 1998

Baltimore, Maryland 21215-0020

be executed

P.O. Box 68760.

Records,

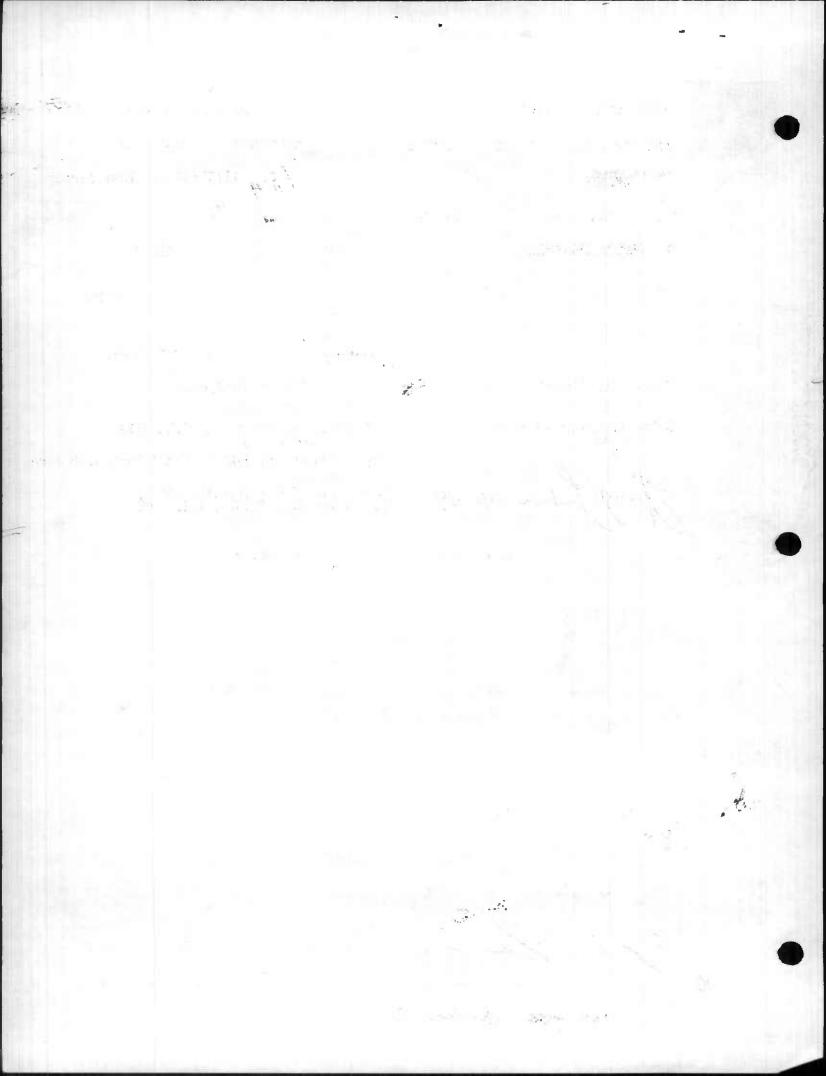
Division of Vital

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certificate

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Daeth Month Godw ,N Leroy ChNNIE 13 PANUARY 0245 1998 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Locetion of Deeth 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 6. Sex 1 M 2□ F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Dete of Birth (Month, Dey, Year) Months Deys Yrs. 55 VIRGINA 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No emperancelli 10e. Street end Number 10g. Citizan of What Country? 14. Race - American Ir Bleck, White, etc. . Wes Dacedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detas: 1. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 131 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highest grade completed) Elamantary/Sacondary (0-12) Collaga (1-4or 5+) construction boyer 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 14ENRY Ames ouveller 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 188 allin BRither OOK OFFice Box HALL Godwin 20b. Ptaca of Disposition (Neme of cemetery, cramatory or other place) 20c. Location - City or Town, State 20e. Mathod of Disposition Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) /emferance. He VA 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility WHANTON FUNDAM Marlos 22171 marrian Rd Accomso UA 2331 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final diseese or condition resulting in deeth) es e consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceusa (Diseesa or Injury that Initieted events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware eutopsy findings eveilable prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 20 No 1 Yes 2 No

Physician /Medicai Examiner that the death certificete be executed

physician

Physician

/Medicai

Examiner

216.

Funerai

Director

28a-f show

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Funeral

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traumatic event, the Medical Examiner must be notified at

GODWING CHIS

Department of Health and Mental Hygiene. Important: if Nem 27 Is marked other than "natural", or Nems 23a any Injury or other traumatic event, the Neutral Examiner must b police.

Pages 1 end 2 should be filled within 72 hours efter nent of Health end Mental Hygiene.

Baltimore, Maryland 21215-0020

Box 68760

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Hospital or Attending Physician: The law requires

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Physician/Medical Be

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25. Wes case referred to medical

3 Suicide 4 ☐ Homicide 29a. Certifier

examiner?

1 Naturel

2 Accident

1 Yes

30 No

29b. Signeture end title of certifier

6 Could not be

5 Pending investigation

28e. Data of Injury (Month, Dey Year)

28a. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

28c. Injury et Work?

28b. Time of

1 Inpatient 2 □ ER/Outpetient 3 □ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No

26. Plece of Deeth (Check only one)

28f. Location (Straat and Number or Rural Route Number, City or Town, Stete)

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30. Name end eddress of person who complated causa of death (Item 23a) (Type, Print)

31. Dete fited (Month, Day, Year)

32. Registrer's Signeture Sulia Davidsor

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as a success of the

State of Maryland / Department of Health and Mental Hygiene 98 02723

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day **Physician** 1998 17, **ELIZABETH** JAN. 12;36 P. M HART.AN /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner CAROLINE NURSING HOME DENTON CAROLINE If Undar 1 Year If Under 24 Hrs. 8, Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foraign
Country) **Funeral** 1□ M 200 F JULY 4,1910 NEW YORK Yrs. 042-40-7531 Director 87 Usual Residence of Deceden with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23s or 28s-1 show event, the Medical Examinar must be notified at MD CAROLINE DENTON 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 S. 2ND STREET 21629 USA death 1 Funeral 12. Was Decedent Evar In U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritai Status 14. Race - Amarican Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yas 2 XNo If Yes, Give Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify þ Specify TE 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 HOMEMAKER OWN HOME Is marked other permit. Pages 1 and 2 should be filt Depertment of Heelth and Mental Hy Important: If Item 27 Is marked oth any liqury or other traumatic event other. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Meiden Sumema) Be KENNETH STUART MCINTYRE TDA CHAFEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) VALERIE TAYLOR/ DAUGHTER 401 S. 2ND ST., DENTON, MD 21629 20b. Place of Disposition (Neme of cemetery, crametory or othar place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) WOODLAWN MEMORIAL 1-20-98 EASTON, MARYLAND 21. Signature of Funeral Service Licensae 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM 1.7/ 200 S. HARRISON ST. EASTON, MD. 21601 E. Newnani 23a. Part1. Enter the disaasa, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting In death) /Medical INTESTINAL OBSTRUCTION 1 DAY Examiner Due to (or as a consequence of) Physician/Medical Examiner ATHEROSCLEROTIC HEART DISEASE 10 YEARS The law requires that the death certificate be axecuted ettanding physician and for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. ORGANIC BRAIN SYNDROME 10 YEARS Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o the signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, ò 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? peen s Completed has certificate 1 ☐ Yes 2 【No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Yes X No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 5 Pending investigation 1 Yes 2 No deeth. Director: / 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide hin 24 hours after de the Funeral Directo nplately filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 29a. Certifler 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 0 de MO D0051132 1-17-1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JORGE H. ABREGO, M.D. DAFFIN LANE DENTON, MD. 21629 32. Registrar's Signatura 31. Date filed (Month, Day, Year) State Julia Savidson Randoll Registrar

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State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** Yaar HARDING Jr. ROBERT JANUARY 06 1998 2:18 AM /Medical 4e. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHORE NURSING & REHABILITATION CTR. DENTON CAROLINE 7. Aga (In yrs. last birthday) If Under 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sex Birthplace (Stata or Foraign Country) **Funeral** 1**X** M 2□ F Deys 79 Yrs. 214-07-7340 Director Mar.3,1918 Del Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or frems 23a or 28a-f show traumatic event, the Magical Examinet must be notified at NO Yas 2 No Director MD. Caroline Denton tha 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1020 North Hertiage Court 21629 USA death Funerai 11. Marital Status 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Spacify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed within Department of Health and Mantal Hygiana. Important: If Itam 27 Ia marked other than "I any Injury or other traumetic event, the Max Elementery/Secondary (0-12) Collaga (1-4or 5+) 11 0 Machine Operator Nylon 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Robert F. Harding Sr. 2 Beatrice Smith 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1020 HertiageCourt, Denton, MD. 21629
a of Disposition (Nama of Data 20c. Location - City or Town, Stata Catherine S. Harding/wife 20b. Place of Disposition (Nama of cematary, crematory or othar placa) 20a. Mathod of Disposition 1 X Burial 2 ☐ Crametion 3 ☐ Ramoval from State East New Market Cem. 1-9-98 East New Market, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funarai Sarvice Licensee 22. Nama and Addrass of Facility Williamson Funeral Home, Federalsburg, MD. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Deeth **Physician** /Medical Immediata Causa (Final netsois Lones 4001) diseesa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examiner sician and burief-transit Saquentielly list conditions, if eny, laading to immadiata ceusa. Entar Undarlying Causa (Diseasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): physician as the buriel Box 68760 Physician/Medical Dua to (or as e consequence of): attanding P.O. Part II. Other significent conditions contributing to death but not resulting in the undarlying ceusa given in Part I. tha 23b. Did tobacco use contribute to the cause of deeth? signed by t 1 Tyes 2 No 3 Probably 4 WUnknown Records. þ 24b. Wera autopsy findings evailabla prior to complation of ceusa of daath? 24a. Was en autopsy parformad? Completed peen has 1 Yas 2 No 1 ☐ Yes 2 No cartificate Division of Vital 25. Was cesa rafarred to madical Be 26. Placa of Daath (Chack only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 2 this 28a. Data of Injury (Month, Day Year) funaral 27. Mannar of Death To the Hospital or Attending Pt within 24 hours aftar death. To the Funeral Director: After th completely filled in by tha funaral 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 1 Netural 5 Panding 1 ☐ Yes 2 ☐ No Investigation 2 Accidant 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicida 29a. Cartifiar 1 Certifying Physicien: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as steted. Medicai (Check only one) 2 Medicel Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature end titla of certifier 29d. Date signed (Month, Day, Yaar) 29c. License number ah D0051132 JANUARY 06, 1998 30. Nema end addrass of person who complated causa of daath (Item 23e) (Type, Print) JORGE ABREGO M.D. P.O. BOX 660 DENTON, MD 21629 31. Data tilad (Month, Day, Year) JAN 1 3 1998 32. Registrar's Signatura State

Registrar

Julia Davidson Randalle

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death **Physician** Month Year Muriel Bergguist Hanish 1998 January 11 1410 /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Kent & Queen Anne's Hospital Chestertown Kent If Under 1 Year If Undar 24 Hrs.

Months Days Hours Min. 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) 6. Dete of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 1□M 2₽F 472-01-6108 Yrs 84 Director NOV.11,1913 ILLINOIS Usuai Rasidence of Decedant the Marylend 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Modical Examiner must be not fred at 1 Yes 2 □ No Director KENT CHESTERTOWN 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? death with 501 CAMPUS AVENUE 21620 Funeral USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 12. Wes Decedant Evar in U,S. Armed Forcas? 14. Rece - American Indian, Biack, Whita, etc. 2 should be filed within 72 hours effer on end Mental Hygiena. 1 Never Merried 2 Merried 1 ☐ Yas ZQQO If Yas, Give Yeer or Datas: Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE by 3√Vidowad 4 □ Divorced Completed 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maldan Surnama) JOHN VICTOR BERGOUIST EMELIA ELVIRA JOHNSON 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Peges 1 end 2.
Department of Heetth elimportant: If item 27 is any injury or other trait KAREN HANISH 29893 TARBUTTON MILL RD, TRAPPE, MD 21673 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20c. Location - City or Town, Steta CHESAPEAKE CREMATION 1-13 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramovel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) CHESTER, MD 21619 CENTER L. L. C.
22. Nema end Addrass of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 23a. Partí. Enter tre disaasé, o complication as Caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. EASTON, MD 21601 Approximete Interval Between Onset end Deeth **Physician** Immediata Ceuse (Final diseasa or condition resulting In daath) /Medical AUTO ROSPINITURAL MANUST Examine Examine ACUTE PMERMANITS 24 Hears physician and s the buriel-trensit Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaase or Injury that initieted evants rasulting in daath) Last Box 68760. Physician/Medical Due to (or es e consequence of) Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed l Records. by 24b. Wera eutopsy findings eveileble prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 🗷 No certificate 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Yas 2 No 27. Menner of Deeth 28a. Deta of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Naturei 2 Accidant 5 Panding 1 ☐ Yas 2 ☐ No invastigation 6 Could not be datarmined 3 Suicida 28a. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 15 Certifying Physician: To the bast of my knowladga, daath occurred et tha tima, data and place, and dua to tha causa(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) and manner steted. Medical 29a, Certifian 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. Licensa number 17-13824 6 - nu 30. Nama and eddrass of parson who complated cause of daeth (Itam 23a) (Type, Print)

State Registrar

31. Data filed (Month, Day, Yaar) JAN 13 1998

32. Ragistrar's Signatura Julia Davidson

JOHN C. SEYMOUR, M.D., 122 SPEER RD., STE. 5, CHESTERTOWN, MD 21620

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Hardy Jerome 1998 11:50AM January 1 Ety, Town, BALTIFIUM If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, Year) Apr. 25, 1932 gility Name (If not institution, give 4b. City, Town, or Location of Deeth 4c. County of Death are (City) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months 100M 20 F 212-30-2583 Maryland 65 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Howard Columbia 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5-17 Harpers Farm Road 21044 U.S.A. 12. Wes Decedent Ever In U.S. Armed Forces? Waa Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. Black, White, etc. 1X Yes 2 No If Yes, Give 1 ☐ Never Merried 2 Married Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Detes: 3 Widowed 4 Divorcad Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Industry Elementary/Secondary (0-12) 9th College (1-4or 5+) Equipment Operator Construction 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clifton J. Hardy Dorothy V. Watkins 19a. tnformant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred A. Hardy (Wife) 5917 Harpers Farm Rd., Columbia, MD 21044 20b. Placa of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State Veterans Cem. Md. 1/23/98 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 21. Signature of Euneral Service License 22 Name and Address of Fecility SNOWDEN FUNERAL HOME ROCKVILLE, MD 20850 23a. Part1. Enter the disease, or combications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Finel MultiForme ioblastoma marth disease or condition resulting in death) Due to (or es a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted eventa resulting in deeth) Last Due to (or es e consequença of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation Natural 1 Yes 2 No 2 Accident

P.O. Box 68760. 8 Division of Vital Records. Attending

sicien and burial-transit the attending physicien ched for use as the buna signed by t been sig paga 2 has this certificata After death. of Attended of the office of t 3 To the Hospital c within 24 hours of To the Funeral D completely filled i

Physician/Medical

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Certification:

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Physician

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Examiner

Director

Funeral

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at

with the Maryland

death

72 hours eftar

permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important if flem 27 is marked other than any injury or other trainment.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

29a. Certifier

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of

2Bc. License number 29d. Date signed (Month, Day, Year)

veurosurge

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Green St. Baltimore MD And rew non 10 MO

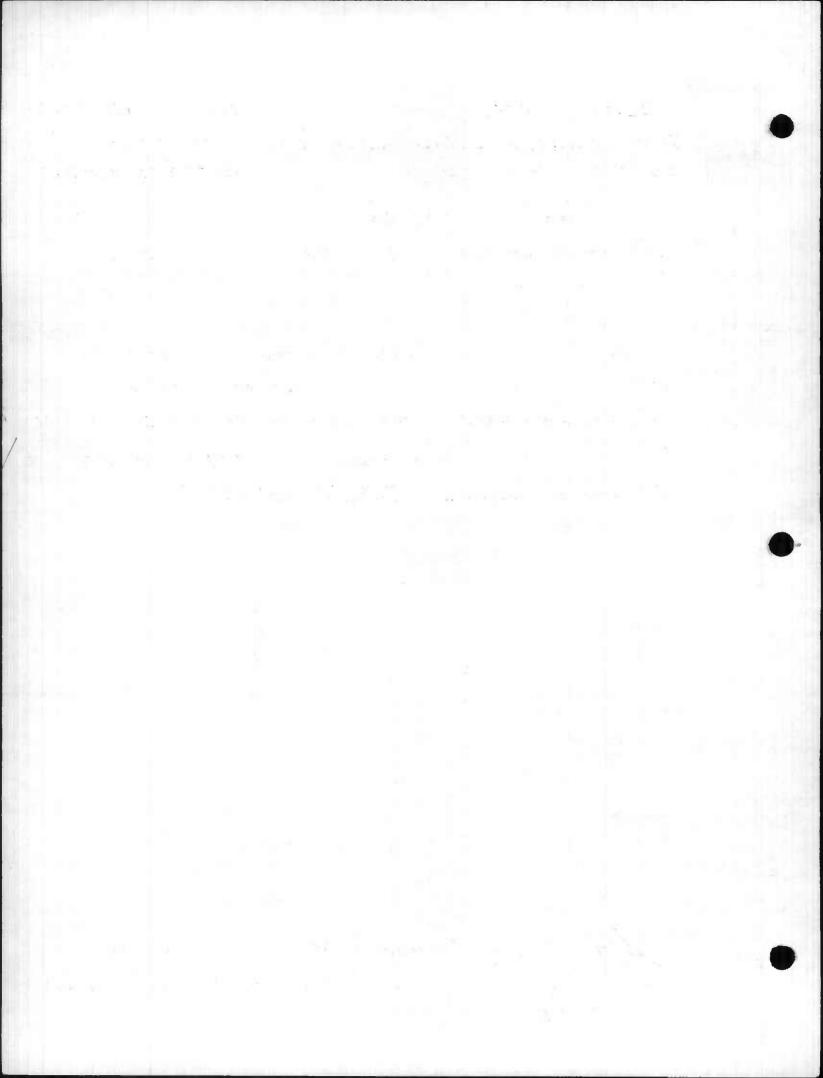
State Registrar 31. Date filed (Month, Day, Year)

8 Could not be determined

32 Registrar's Signature Julia Davidson

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

St



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Death January 17, Month 1998 P. Healey Louise 8:55 AM 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Genesis Eldercare Layhill Center Montgomery Silver Spring Months Days Hours Min. 8. Date of Birth Month Day, May 20, 5. Social Security Number 9. Birthplace (State or Foreign Country)
Puerto Rico 7. Age (In yrs. last birthday) 1 M 2CXF Yrs. 103-05-8631 82 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₺ No Maryland Montgomery Silver Spring 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 3227 Bel Pre Road 20906 United States 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Bleck, White, efc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 XYes 2 No Specify: 3XXWidowed 4 □ Divorcad White Puerto Rican 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Classified Ad Salesperson Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) luan Martin Paradise Delores Mari 19a. Informent's Name/Relationship (Type, Print) (private geriatric 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Thistle Court, Debra Levy care manager Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 D Burial 2 Cremetion 3 Removal from State 4 ☐ Donefion 5 ☐ Other (Specify) Norbeck Memorial Park 11-20-98 Olney, Maryland 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Pert1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsel and Death Immediate Cause (Finel disease or condition resulting In death) Multiple Organ Failure 3 months Due fo (or as e consequence of): Type II Diabetes Mellitus years Due to (or as a consequenca of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medicai **Examiner**

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V Director: Ah.

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To the Hospital of within 24 hours of To the Funeral D completely filled in

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter c Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel" or iten any injury or other traumatic event, in a Michigal Evantina.

with the Maryland

death

Examiner physician end the buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated excesses) Physician/Medical thet initiated events resulting In death) Lest use as

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Alzheimers Dementia

25. Was case referred to medical 1□ Yes 2□ No

27. Manner of Deeth 5 Pending Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homleide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. 29a. Certifier

28e. Date of Injury (Month, Day Year)

28c. Injury et Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signeture end fitte of certifier

29c. License number D15405

29d. Dafe signed (Month, Dey, Year) January 17, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D., Cezar A. 18111 Prince Philip Drive, Olney, MD 20832 Lopez, M.

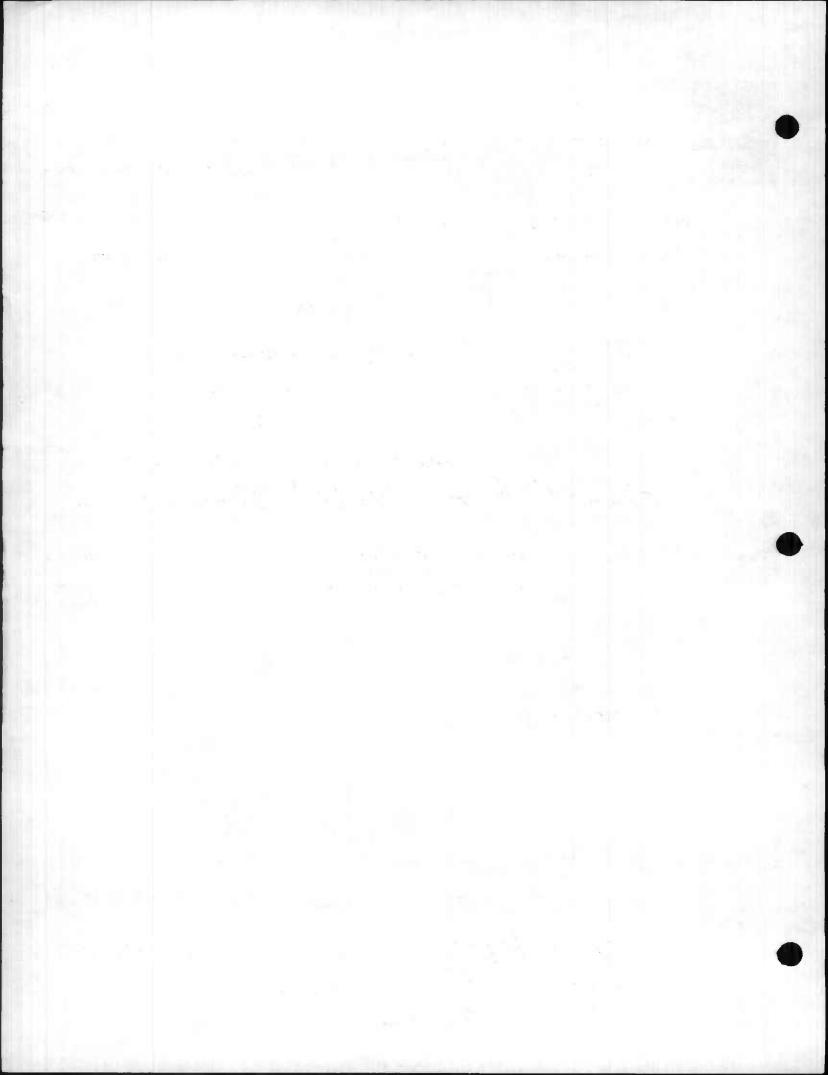
31. Date filed (Month, Day, Year) JAN

(Check only one)

20

32. Registrar's Signature Julia Savidson

State Registrar



State of Maryland / Department of Health and Mental Hygiene 98

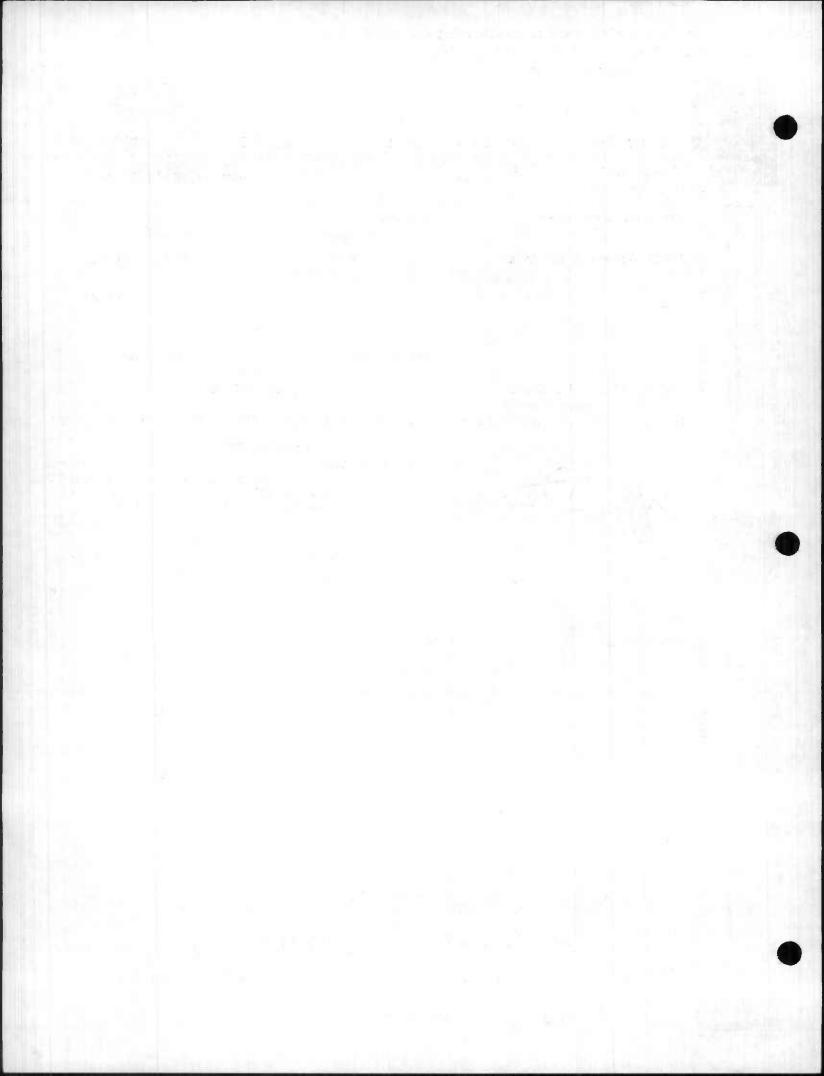
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72 hours efter deeth with the Maryland naturel', or items 23a or 28a-f show piral Examiner fruit be notified at	Die	10e. Street and Number	e. Street and Number						10g.	Citizan of V	What Countr	у?	
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	by Funeral	11. Marital Status 1 □ Navar Married 2 □ Married 3 ☑ Widowad 4 □ Divorced	12. Was Dacadant E Armed Forcas? 1 ☐ Yas 2 ☒ N If Yas, Giva Yaar or Datas:		lf.	as Decedant of Yas, specify Cub ☐ Yas 2 ☑ No	oan, Maxican,	jin? (Spacify Y , Puarto Rican,	as or No- atc.)	Blac	a - Amarica ck, Whita, at :: Whi	tc.	
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within 24 hours efter To the Funeral Directory completely filled in the	edical Co	29a. Certifiar 12 Certifying Ph	ysician: To the best o	t my knowledga	, death o	occurred at tha t	ima, data and	i place, and du	a to tha caus	a(s) and ma	annar as sta	itad.	
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St	ate	31. Data tiled (Month, Day, Year)	32, Ragistra	r's Signatura									

Registrar

JAN 23 1998

32 Ragistrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month BRTAN HENDERSON DAVID JANUARY 9:15 AM 4e. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 11814 Ashbrook Court Germantown Montgomery | If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye Nov. 9, 1 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplace (Stete or Foreign Country) 1 € M 2 □ F 220-58-7956 38 Yrs. Wash., Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11814 Ashbrook Court 20876 United States 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Giva Year or Detes: 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxicen, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 1 Navar Married 2 Married 1 Yas 2 No Specify: white Specify. 3 Widowed 4 Divorced Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Bueiness/Industry Elementery/Secondary (0-12) College (1-4or 5+) Engineering/Private Systems Engineer 17. Father's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumeme) Raymond Henderson Dolores Walters Henderson 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) Leslie Anne Henderson /wife 11814 Ashbrook Court, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, cremetery or other place)
Ft. Lincoln Crematory 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 Cremation 3 ☐ Removel from State 1/22/98 Brentwood, MD 4 Donetion 5 Other (Specify) Name end Address of Fecility Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, MD 20904 Approximete Intervel D Pert 1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Onset and Death Immediate Ceuse (Final Pheachromocytoma · Metastate diseese or condition resulting in death) Due to (or es e consequence of) Due to (or es a consequence of) Due to (or es e consequance of)

Physician /Medical Examiner

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page 2

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The law requires that the death certificate be executed

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Division of Vital or Attanding Physician: 10

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r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within nent of Health end Mental Hygiene. Int: If Item 27 is marked other than Irry or other treumstic event, the Mark

permit. Page Department of Important: If any Injury or

filed within 72 hours efter deeth with the Meryland

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Disaese or injury that initieted events resulting in deeth) Last

25. Was case referred to medicel

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

1.21-58

24e. Wes en eutopsy performed?

1 ☐ Yas 2 ☐ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 28e. Deta of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Maturel

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not ba 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

(Check only one) 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end manner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

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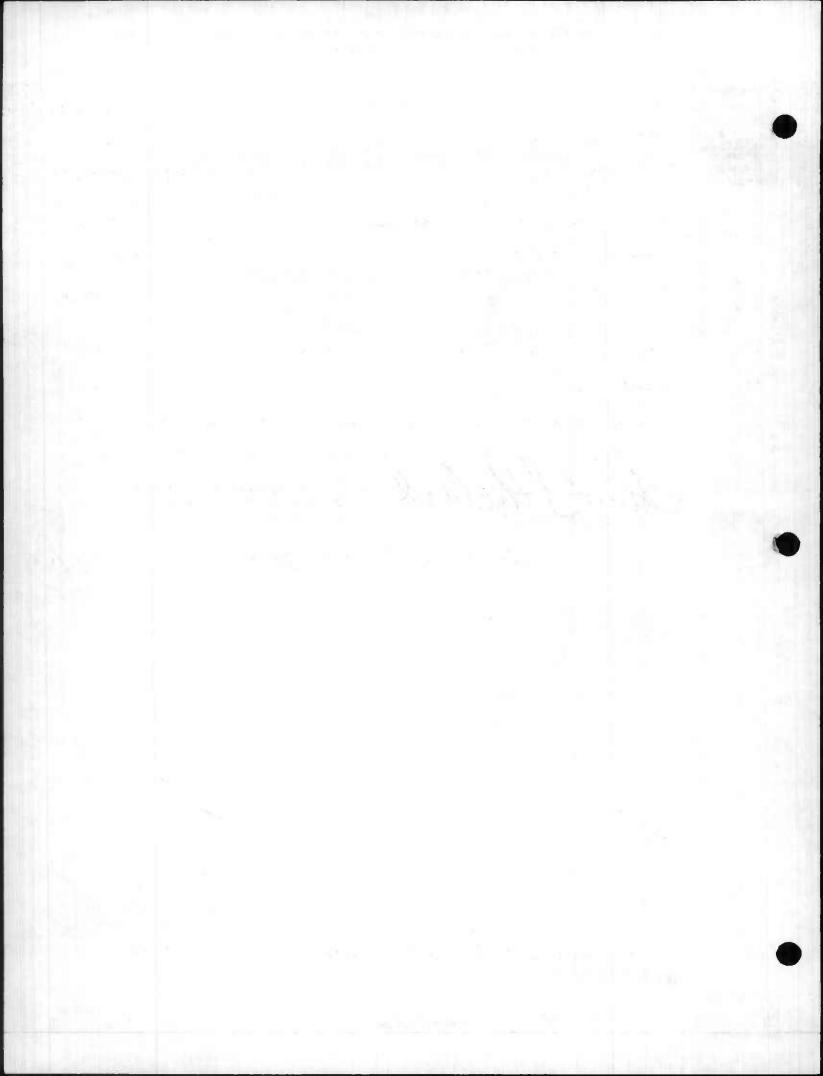
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Frederick G. Barr 2101 Medical Park Dr.; Silver Spring, MD 20902

State Registrar 31. Dete filed (Month, Dey, Year)

JAN 2 3 1998



DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

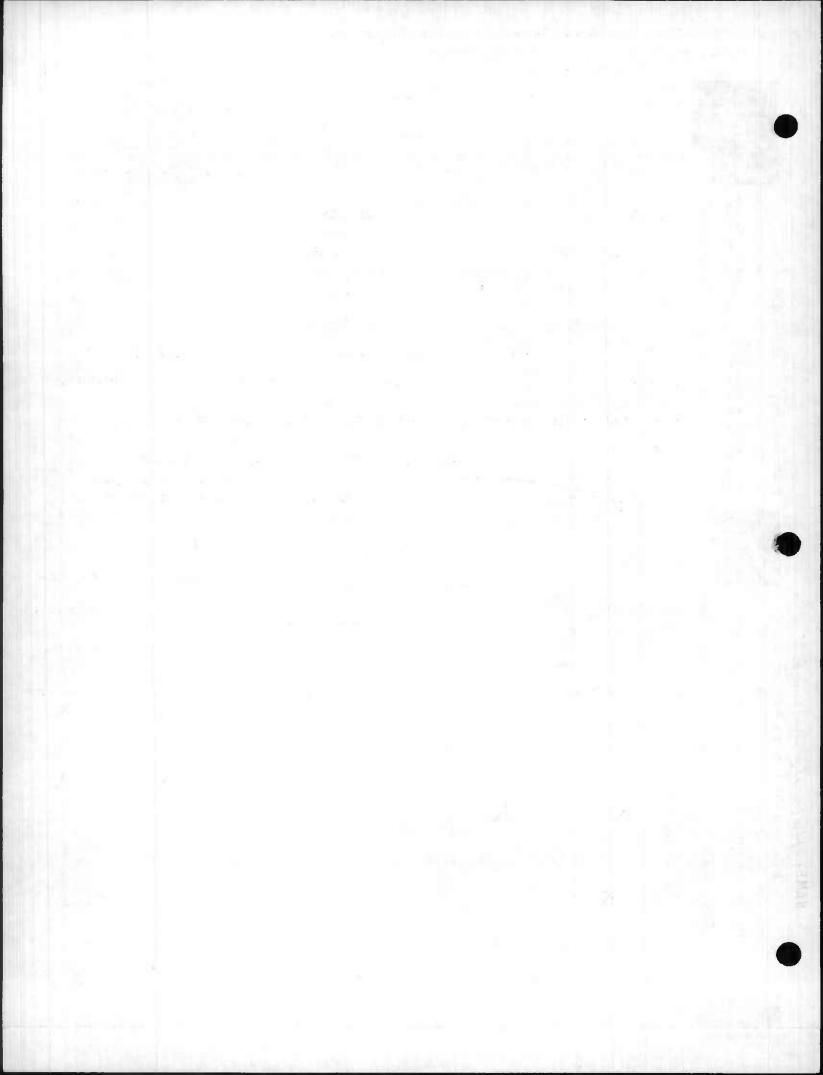
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death HUDSON **Physician** MEGINNEY Month TaN /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 900 CATON AVE. ST AGNES HOSPIEAL. BaltimoRE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign **Funeral** 216-05-9490 90 Yrs. AUG.5, MARYLAND Director Usual Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28a-f show MARYLAND N/A BALTIMORE 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21229 WILKINS AVENUE U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Merital Stetus "naturel", or items filed within 72 hours efter 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☒ No Specify: WHITE þ 3 Ø Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) N/A Elementary/Secondary (0-12) SELF EMPLOYED RESTAURANT/BAR .. Peges 1 and 2 should be filed w tment of Heelth and Mental Hygler tant: If item 27 Is marked other th jury or other traumatic event, Its Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE HUDSON GERTRUDE Τ. MEGINNEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL ANN WAGNER (DAUGHTER) 241 WICKLOW AVENUE, GLEN BURNIE, MD. 21061 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Deurial 2 Cremetion 3 Removel from State Department of Important: If any injury or once. 1/21/98 4 ☐ Donation 5 ☐ Other (Specify) ST. PETER'S CEMETERY QUEENSTOWN, MD. 21. Signeture of Fundal Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** immediate Ceuse (Final disease or condition resulting in death) /Medical Premonia Examiner Due to (or as a consequence of): 1 week Examiner AOTHE SHENOSIS death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Un Known Hyper Kalemia Physician/Medical the Due to (or as a consequence of): / day. for use es signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? SAMU 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? HUDSON page 2 this certificate 1 Yes 1 ☐ Yes 2 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 1 Natural Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending Investigation 1 Yes 2 No 2 Accident efter deetl Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital c within 24 hours of To the Funeral D completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 11703 Samir Kheiri MD Jan, 18, 1948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) same and address of person who completed cause of death (Item 23a) (Type, Print)

SAMIR KHEIRI - St AGNES HOSP. 900 CATON Ne - Bulkingere
21229 MD 31. Date filed (Month, Day, Year)

JAN 2 0 1998 32. Registrar's Signature State Julia Davidson-Randalle Registrar

DHMH 16 Rev 6/95



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Physicia: /Medica	al	1. Decadent's Name (First, Middle, Last MARION HOFF MA 4. Secility Name (If not institution gives	7			4h City Tourn or l	2. Date of De Month	Dey Ly 16	1998	Time of Death				
Examine Funeral Director	er	4a. Facility Name (If not institution, give UNIVERSITY OF MAR 5. Social Security Number 217-42-9450 Usuaf Residence of Decedent	YLAND MI		day) If Under 1 Year			BALTI	MORE	(State or Foreign				
show		10a. State 10b. County		10c. City, Town	or Location					nside City Limits				
really with the Maryland	Director	MARYLAND ANNE ARU 10e. Street and Number 1421 GESNA DRIVE	NDEL	HANOVE	R 10f. Zip Code 210	76	10g. Citizen of What Country?							
or so the	by Funeral	11. Marital Status 1 Never Married 2 Marriad 3 Widowed 4 Divorced	12. Was Decadent Armed Forces? 1XX/es 2 If Yes, Giva Year or Dates:		13. Was Decedent of I	Hispanic Origin? (Sş an, Mexican, Puerto	pecify Yes or No Rican, etc.)		e - American fr k, Whita, etc.	ndian,				
Hygiene. ther than "natural", ant, the Medical Exe	Completed	15. Decedent's Education 16a. Dece			decedent's Usual Occul Give kind of work done ife. DO NOT use retire N.S.A.	during most of work	king	16b. Kind of Bu		у				
or Mental Hygiene. I merked other than umetic event, tra Mental Control Control The Mental Control Control The Mental Cont	To Be			R.		18. Mother's Nam	J	ANE	STO					
Department of Health 2 std Department: If item 27 is me any injury or other traum ance.		19e. Informent's Name/Relationship (7) ELAINE GOSNELL HOP 20a. Method of Disposition	FMAN (WIE	E) 14	Maifing Address (Street 21 GESNA D Disposition (Name of crematory or other pla	RIVE, HAN			21076					
Department of I		1 Suriat 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funda Service Control			IDGE MEMOR 22. Name and Addre	IAL PARK	1/20/98	ELKRID	GE, MAF	RYLAND				
Departr Importa any Inji		23a. Part1. Enter the disease, or compleshock, or finant failure. List only o	+		SINGLETON 1 SECOND	FUNERAL AVE. S.W.	, GLEN		MARYLA	ND 2106				
		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated events resulting in death) Last	b	Due to (or as a co	nsequence of):	LEUKEN	11A .		3	WEEKS				
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ral Director: /	Cerimo	3 Suicide 6 Could not be determined		28f. Location (Street end Number or Rural Route Number, City or Town, State)										
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		30. Name and address of person who co	22 Pegistr	South 6	GREENE ST	REST, B	ALTIMO	RZ, MD	2120	1				
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P.O. Box 68760

Division of Vital

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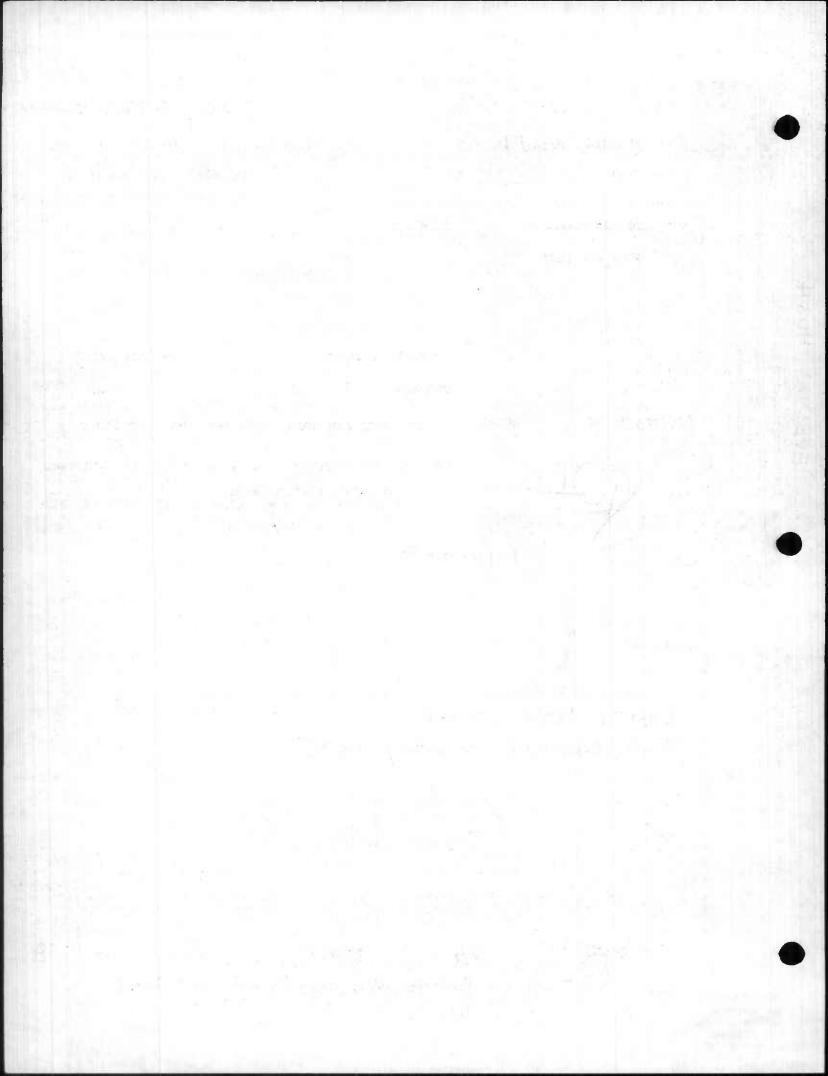
funeral

with the Maryland

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1, Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 9:30 A.M **EVELYN** January ANNA HUSH /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** North Arundel Glen Burnie Hrundel Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 2፟ØF Yrs. Director 216-01-5593 87 MARCH 31, 1910 MARYLAND Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumstic evant, the Modical Examiner must be notified at 1 ☐ Yes 2 X No Director MARYLAND BALTIMORE GLEN ARM 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6201 GLEN ARM ROAD 21057 U.S.A. Funeral 12. Was Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puento Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Yeer or Dates: 1 ☐ Yes 2 No Specify: Specify: p 3 Widowed 4 □ Divorced WHITE Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiena. Important: If fear 27 is marked other than "na any injury or other traumatic evans and ends." Elementary/Secondery (0-12) College (1-4or 5+) 8 0 PAYROLL CLERK GROCERY STORE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) BERNARD COOLAHAN 0 LENA STOLL 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DONNA WATTS (NIECE) 6201 GLEN ARM ROAD, GLEN ARM, MARYLAND 21057 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriat 2 □ Cremetion 3 □ Removel from State 5 Other (Specify) 4 Donetion NEW CATHEDRAL CEMETERY 1/20/98 BALTIMORE, MARYLAND 21. Signeture of 22. Name end Address of Fecility SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximete Interval Between Onsef end Deeth **Physician** PNEUMONIA /Medical Immediate Cause (Final) disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician and ss the buriel-transit Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Couse (Diseese or Injury that initiated events resulting to deeth) Lest Due to (or es e consequença of) Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No CONTESTIVE þ 24b. Were eutopsy findings avelleble prior to completton of cause of death? 24e. Wes en eutopsy performed? Completed OSSTENCTIVE PULMONARY DISEASE 1 Yes NO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer?
1 ☐ Yes 2 ☑ No Be 26. Plece of Deeth (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA 1 Impafient 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury ef Work? 28d. Describe how Injury occurred Certification: 28b. Time of 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homictde To the Hospital within 24 hours of To the Funeral Completaly filled 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner as steted. Medical (Check only one) 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSBITAL DOWE, GRENBURNIE. JAN 2 0 1998 32. Registrer's Signeture State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death A.A.CO. 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** JAN. 12 1998 10:10 pm JOHN /Medical 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNAPOLIS

Undar 24 Hrs.

Hours Min. ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL If Under 1 Year 8. Data of Birth
JULY 71910 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foraign GEORGIA **Funeral** 1□M 2□F Months Days 579-03-1602 87 Yrs. Director Usual Rasidance of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examinat must be notified at 1 Yas 2 No Directo MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? with 21403 Funeral 3335 ARUNDEL ON THE BAY ROAD deeth US 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 11. Maritai Status filed within 72 hours efter 1 Yas 2 No
If Yas, Give
Year or Datas: 1 ☐ Nevar Married 2 Narriad 1 ☐ Yes 2 XNo Specify: BLACK Specify: þ 3 ☐ Widowad 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry al Hygiane. Elemantary/Secondery (0-12) Collega (1-4or 5+) 11th EXECUTIVE MOTOR POOL PENTAGON permit. Pages 1 and 2 should be file.
Department of Health and Mantal Hy
Important: If Item 27 is marked other
any injury or other traumatic avent 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be JOHN HESTER ETHEL HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Route Numbar, City or Town, State, Zip Coda) 3335 ARUNDEL ON THE BAY RD. ANNAPOLIS, MD. 21403 FRANCES HESTER (WIFE) Baitimore, 20b. Placa of Disposition (Nama of cametary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata /15/98 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) BALTIMORE, MD. METRO CREMATORY 21. Signatura of Funaral Sarvice Licensas 22. Nama and Addrass of Facility WM. REESE & SONS MORTUARY, P.A. Lavy S. T 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Pert1. Entar tha diseasa, or complications that caused tha death. Do not enter the mode of dying, such es cardiac or respiretory errest shock, or haart failure. List only one cause on aach lina. **Physician** /Medicai tmmediata Ceuse (Final disaasa or condition resulting in daath) Examiner 9 105 Fee entestura physician and the burial-trans Sequantially list conditions, if any, laeding to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that initiated avants resulting in daath) Last Dua to (or as a consequenca of) wen we Physician/Medical Dua to (or as a consequence of): 80 USB for ed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 3 ☐ Probabty 4 ☐ Unknown TO Yes 20 No won wsulude Records, þ 24b. Wara eutopsy tindings available prior to completion of causa ot death? Completed 24a. Was an autopsy has page 2 1 Yas 2 No 1 Yas 2 4NO Division of Vital I funeral director, 25. Wes casa rafarrad to medicat axaminar? 26. Placa ot Daath (Check only ona) Be Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 -No 1 Umpatient 2 ER/Outpatiant 3 DOA this 27. Mannar of Death Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Atvatural 5 Pending I or Attendin after death. I Director: Aft d in by the fur 1 Yas 2 No Invastigation 2 Accident 6 Could not be datamined 3 Sulcida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homloida To the Hospital of within 24 hours at To the Funeral D completely filled it 29a. Cartifiar edical 1 Cartifying Phyalclen: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) end mennar as stated. (Check only one) 2 Medicat Examtner: On the basis of axamination and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of certities 29c. Licensa number 29d. Data signad (Month, Day, Year)

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completed cause of death (Itam 23a) (Type, Print)

hia Davidson

32. Degistrar's Signatura

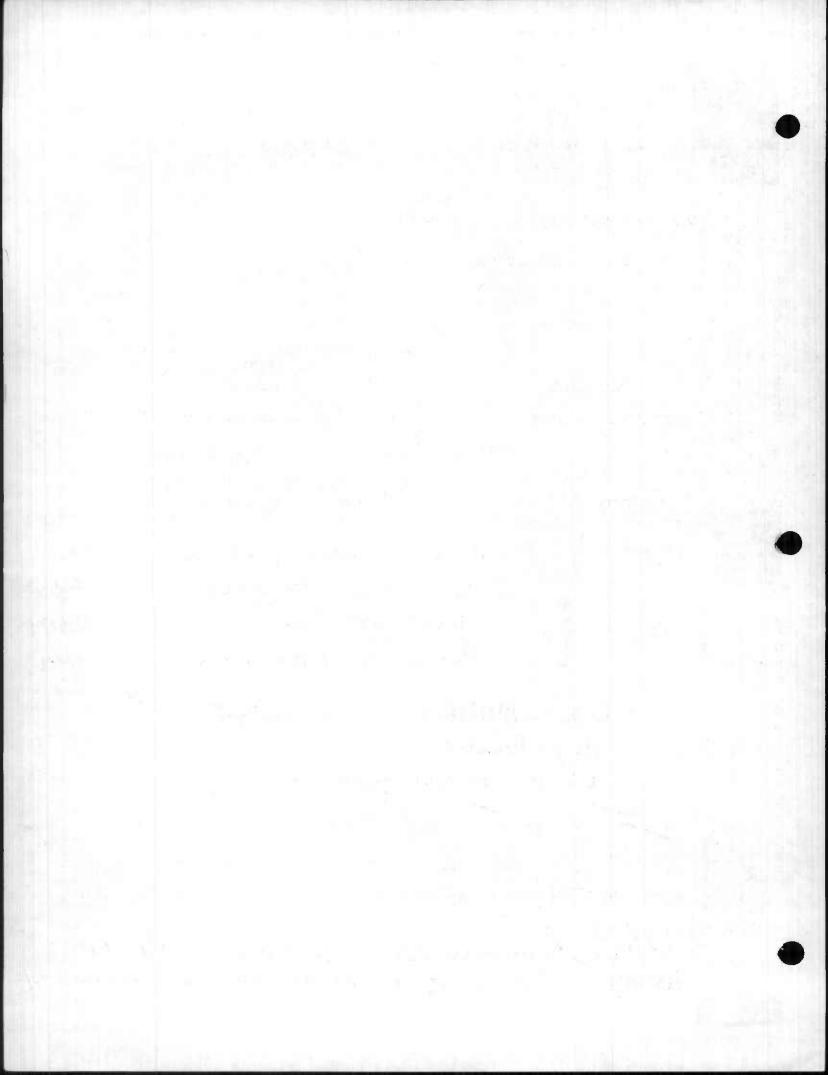
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of person who

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31. Data tilad (Month, Day, Yaar)

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First Middle Last) 2. Date of Daath **Physician** Month HELMLY CECIL CALVERT 6.30 PM Kungry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner North Aroundal Hospital GLEN BURNIE ANNE ARUNDEL If Under 1 Yaar If Under 24 Hrs. Months Days Hours Min. 8. Data of Birth (Month, Dey, Year) JUNE 22, 1901 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign 1 □ M 2 □ F 96 249-64-2060 Vrs GEORGIA Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Director MARYLAND ANNE ARUNDEL SEVERN 1 ☐ Yas 2 X No 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 21144 8121 PASTURE COURT U.S.A. Funeral 12. Was Dacedent Evar In U,S. Armed Forcas? 1 □ Yes 益的 No If Yas, Giva Yaar or Dates; 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) Race - American Indien, Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) MINISTER LUTHERAN CHURCH 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) Be SHADRACK EDWARE HELMLY GEORGE OLTVIA 19e. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) PAULINE B. HELMLY (WIFE) 8121 PASTURE COURT, SEVERN, MARYLAND 21144 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, State Burlal 2 ☐ Cramation 3 ☐ Removal trom Stata 4 ☐ Donation 5 ☐ Othar (Spacify) ROSEMOUNT CEMETERY 1/24/98 NEWBERRY, S.C. 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 complications thet caused tha deeth. Do not antar the mode of dying, such as cerdiec or respiretory errast, mly one cause on each line. Approximata tnterval Batween Onsat and Death tmmediata Ceuse (Final disaase or condition rasulting in daath) Sequantially list conditions, if any, leading to immadieta ceuse. Entar Undarfying Causa (Disaase or Injury that initiated evants resulting in daath) Lest Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Severe Anemia 24a. Was an autopsy performed? 24b. Wara autopsy tindings availabla prior to complation of cause of death? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only ona)

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To the Hospital within 24 hours a To the Funeral C completely filled

In by

Medical

Box 68760,

P.O. 1

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Division of Vital

Funeral

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Department of Health Important: if Item 27 any Injury or other ti once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

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Examiner Physician/Medical by Completed funeral director, Certification: To

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29a. Cartifier

1 Natural

2 ☐ Accidant

3 ☐ Sulcide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner steted.

29b. Signature end titla ot certitiar Elassal,

29c. Licansa number Be 5333644 29d. Date signed (Month, Day, Yaar)

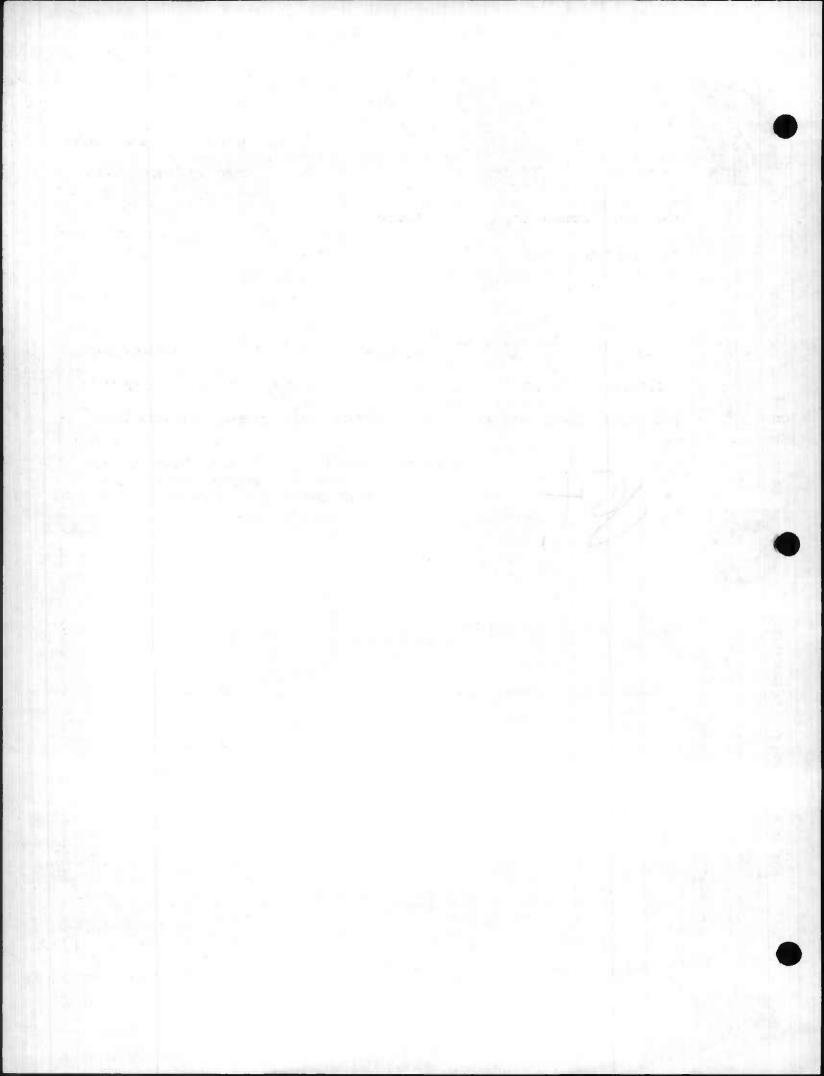
30. Name end eddrass of person who complated causa of death (Itam 23a) (Type, Print)

Sherif Elassal. North Aroundal Hospital 301 Hospital Drive Glen Burmie, MD 21061 31. Data filed (Month, Day, Year) JAN 2. 1998

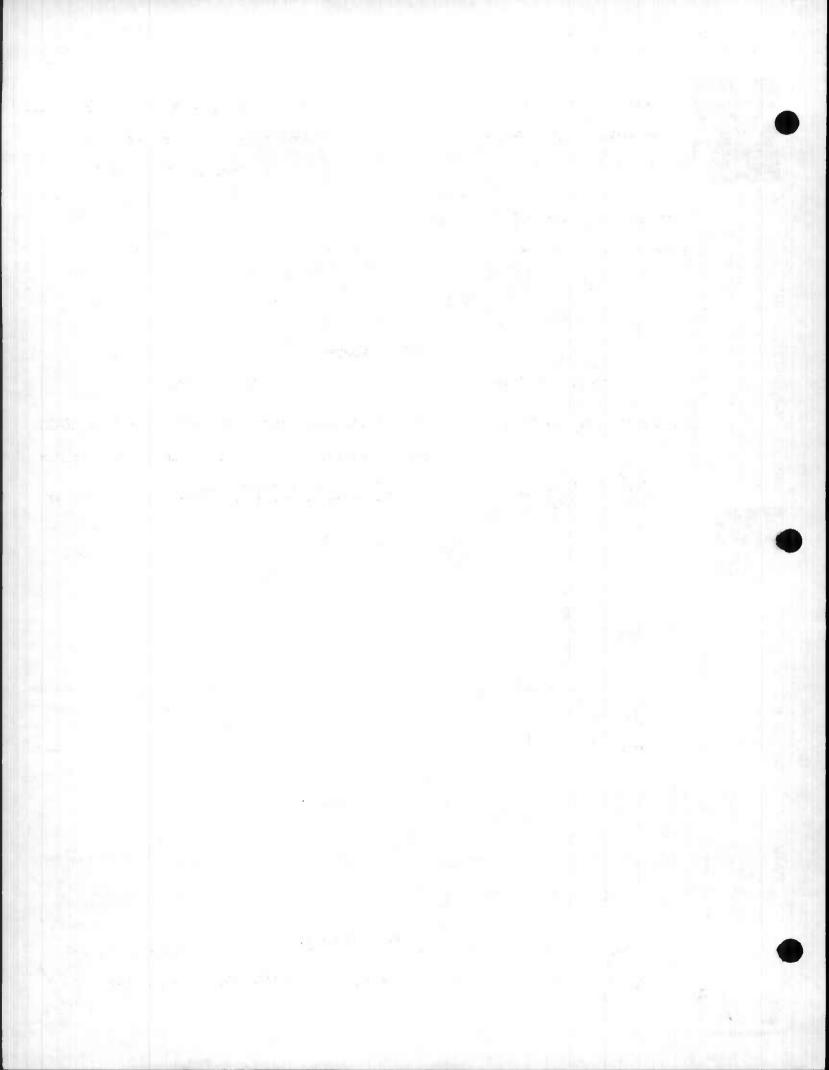
State Registrar

32. Redistrar's Signature here Davidson-Randell

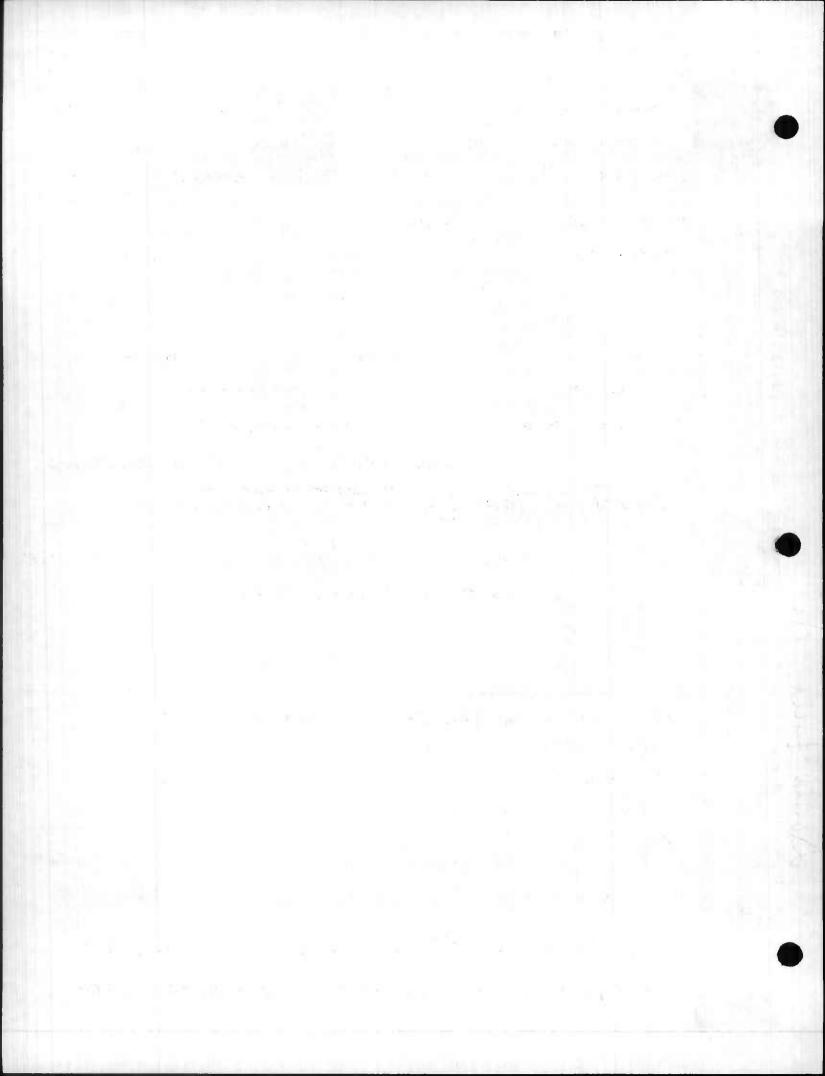
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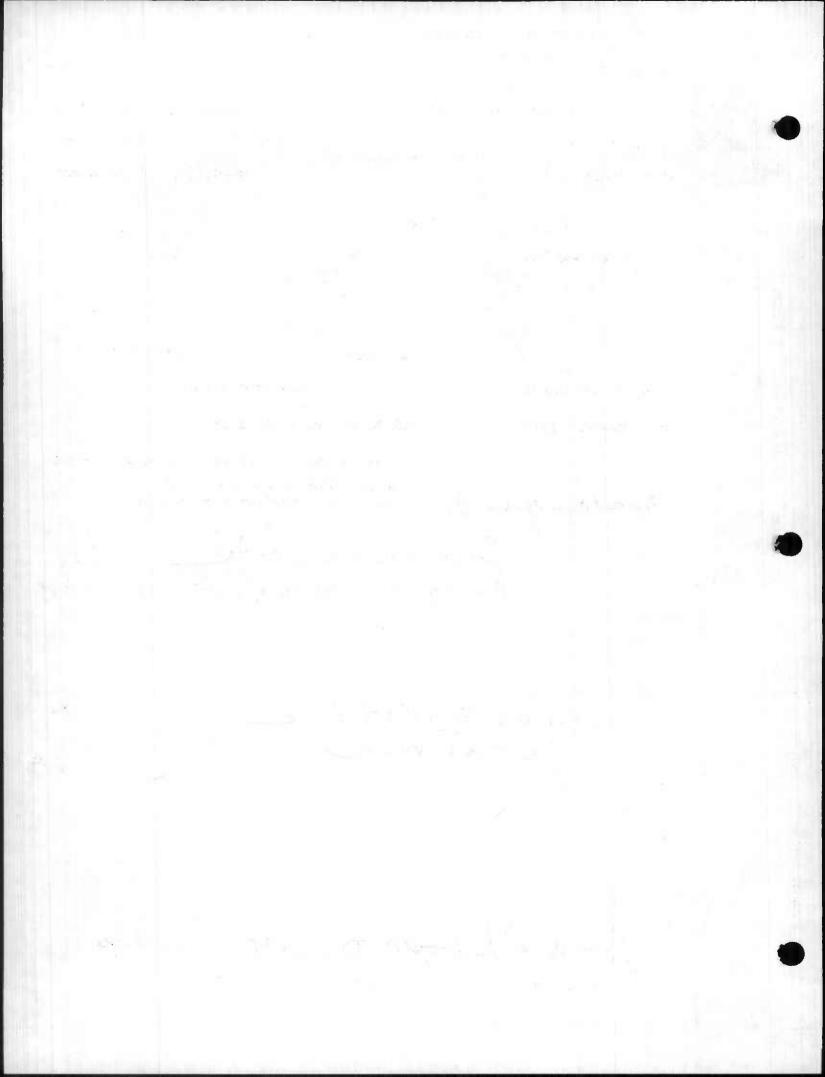


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		PHYSTCIANS		RIAL HOSPI			H I lade a 1 Von	LAPLAT			RLES	
Funeral Director		5. Social Security Number 220-50-9630 Usual Residence of Decede		X 7.7 QM 2□F	Age (in yrs.	48 Yrs.	If Under 1 Yea Months Days		(Month, Dey	Year) 27, 194		oce (State or Foreign y) yland
death with the Marylend rms 23s or 28s-f show Linux De notified at	_	10a. Stete 10b. C			10c. Cit	ty, Town or Lo	cation				10	d. Inside City Limits
Pa-f	Director	Maryland Ch	arles		Wa	ldorf						1 ☐ Yes 2 ☐ No
or 2	Oire	10e. Street end Number					10f. Zip Code		1	0g. Citizen of 1	Whet Country	y?
23a	ie	3047 October H	lace				20602			U.S.	Α.	
Baltimore, Maryland 21215-0020 permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryler Department of Health and Mentel Hygiene. Important: If tem 27 is marked other than "natural", or flams 28 or 28e-f show any livity or other traumatic event, the Medical Examinations to notified anotics.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ 3 □ Widowed 4 □ Div		12. Wes Deceder Armed Force 1 Yes 2 If Yes, Give Yeer or Deter	s? ≬No		Was Decedent of f Yes, specify Cul I ☐ Yes 2 ☒ No	Hispenic Origin? (S ben, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e - Americe ck, White, e : Blac	tc.
5-0 2 ho	ted	15. Dec	edent's Edu	cetion		16e. Deced	ient's Usuei Occu	petion		16b. Kind of B		
Pin 7	pie	(Specify only) Elementery/Secondary (0)		le completed) College (1-4o	(E .)	(Give	kind of work done DO NOT use retin	during most of wo	rking			
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Maryland 212 d2 should be filed with and Mentel Hygiene. 7 is marked other than traumatic event, the M	Be C	17. Fether's Neme (First, M	iddle, Last)					18. Mother's Ne	me (First, Middle,		107	
fente by ked ked	To E	George Howard	Plater					Ida Eli	zabeth Hol	-		
shou with war	-	19a. informent's Neme/Rele				19b. Mailin	g Address (Stree	et end Number or Ri			Stete, Zip (Code)
Malith a silth a 27 is r tra		Gloria Ann Holt	Spc	ouse		3047	October P	lace Waldor	F MD 2060)		
re, N s 1 end 3 l Health tem 27 other tr		20e. Method of Disposition	Орс	doc	20b. F	Place of Dispos	sition (Neme of		T	20c. Location -	City or Tow	m, Stete
Baltimore, semit. Peges 1 er Department of Hea mportant: If Item 2 my Injury or other 2006.		1 Nauriel 2 Crema			6		netory or other pla					
Itin		4 Donetion 5 Oth			Ch		morial Gar		1/14/98	Leonard	town, N	Maryland
Baltimo pemit. Peg Department Important: Il any Injury o		21. Signeture of Funerei Se	111	-10	-	Ma	. Neme end Addr	Gardiner Em	neral Home	РА		
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Examiner	н	resulting in death)		CAR	Due to	71	XX II Y I	TIME			+1	EW HOUR
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Sion O ending Ph eath. or: After th the funeral	it e		ending vestigation	(Month, E	ey rear)	Injury		onk?]Yes 2∐No				
Division of Vita or Attending Physicien: efter death. Director: After this certific in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Plece of i	njury - At he	ome, ferm, stre	et, fectory, office		28f. Location (S	reet end Numb	er or Rurei	Route Number,
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Division To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fun	edicai C	29a. Certifier 1X Certifier (Check only one)	tifying Phys dical Examin	sician: To the bes ner: On the basis end menner:	of examine	wledge, deeth tion end/or inv	occurred et the t estigation, in my	ime, dete end plece opinion, deeth occu	e, end due to the curred et the time, d	euse(s) end me ete end plece,	enner es ste end due to t	ted. he ceuse(s)
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		30. Neme and eddress of pe	10000	0	deeth (Iten	n 23e) (Type, I		20004		10/() - 1 (3
W		30. Neme and eddress of personal Animangand I a 31. Dete filed (Month, Day)	rson who co	ompleted cause of	Rt. 5 &		Print) Reach Rd		2 Charlot			



	Baltimore, Marylan	permit. Pages 1 and 2 should be
•	7	Př / E:
ANthony	Division of Vital Records, P.O. Box 68760,	polytical or Attending Physician: The law requires that the death certificate be axecuted TO Attending Physician: Pages 1 and 2 should be
William	I Records	The law require
ME: Humenik, William ANthony	vision of Vita	Attending Physician:
ME:	Ö	pital or

Physic		d December No.	(First AF-14	f and		Cel	rtificate of	Death		leg. No.		
/Medi	cal	1. Decedent's Name Will 4e. Fecility Name (If n	iam An	thony Hur		Sr.		4b. City, Town, or	2. Dete of Dee Month January	Dey	Yeer 1998	3. Time of Death 1:10 P.M
Exami	ner	St. Mary						Leonard			St. Ma	ry's
uneral irector		5. Social Security Nur 197-20-5	819	5. Sex 1)∑ M 2□ F	7. Age (In yrs.	last birthdey) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey November	Year) 14, 1928	9. Birthple Countr Penns	ce (Stete or Foreign
show		Usual Residence of D	Decedent 10b. County		10c. Cit	ty, Town or Lo	cation				100	d. Inside City Limits
coffieds	Ď		St. Ma	wss to		Hollywo						1 ☐ Yes 2 ☐ No
III	Director	Maryland 10e. Street end Numb		Ly 5		HOTLYWO	10f. Zip Code		1	log. Citizen of V	Whet Countr	y?
		23828 Mer	vell Dear	n Road			206 36			U.S.A.		
	by Funeral	11. Maritel Stetus 1 Never Married 3 Widowed 4		Armed Fo	2 □ No		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispenic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		e - Americar ck, White, et : White	c.
	Completed	(Specify	5. Decedent's	Education grede completed)		16a. Deced	dent's Usuel Occup	petion during most of wor	rkino	16b. Kind of Bu	usiness/Indu	stry
	mpl	Etementery/Second		College (1		life. I	DO NOT use retire	d)		D-1-41	ים ניים	
	ပိ	17. Fether's Neme (F	irst Middle L	2		Owne	er/Operator		me (First, Middle,	Retail		Lore
	To Be		James H						therine Kl		,0)	
	F	19e. Informent's Nem				19b. Meilir	ng Address (Street	end Number or Ru			Stete, Zip C	Pode)
		Mary L. Hu	menik	Spouse		P.O.	Box 953	Hollywood,	MD 20636			
		20e. Method of Dispo-	sition			Place of Dispo	sition (Neme of netory or other ple	ce)	Dete	20c. Location -	City or Tow	n, Stete
		4 Donetion 5		Removel from cify)		arles Me	emorial Gar	dens	1/16/98	Leonardt	own, Ma	aryland
ian cal ner	Examiner	Immediete Ceuse (Fi disease or condition resulting in death)	nal	a (Para	liog	enic	_She	rck			Donset end Death
	dical	Sequentially list cond if eny, leading to imm cause. Enter Underly Ceuse (Disease or in that initiated events resulting in death) Le	st	c. d.	Due to (o	or as a consequence as a consequence of the consequ	dence of);	andia	Physical Control of the Control of t	obacco use con	htribute to t	he causa of death?
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	by Physician/Medical	resulting in death) Le	st	a descontributing to de	Due to (o	r as a conseq	dence of);	egn in Pert I.		res 2□No	3 Proba	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Deeth 3. Time of Death Day January 20, 1998 4:15 PM Ernest Smith Hodges 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, giva street and number) St. Mary's Nursing Home Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 1XM 2□ F Yrs. 577-10-6568 October 11, 1909 Maryland Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland St. Mary's Avenue 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 23275 Coltons Point Road 20609 U.S.A. 14. Race - Amarican Indian, 12. Was Dacedant Evar in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puarto Rican, atc.) Black, Whita, atc. 1 ☐ Yas 2 ☒No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: 3 Widowad 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12th Supply Clerk U.S. Government 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Thomas Gonsalvo Hodges Virginia Gibson 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) PO Box 177 Coltons Point, MD 20626 Eleanor E. Wormwood Daughter 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) All Saints Episcopal Cemetery | 1/23/98 | Avenue, Maryland 21. Signatura of Funaral Sarvice Licensa 22. Nama and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. and Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory areast, Approximately and a cause on each line. Approximata Intarval Between Onsat and Death Immediata Ceusa (Final une (ance disaasa or condition rasulting in daath) Due to (or as a consequence of): Sequantially list conditions, if eny, laading to immedieta causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Due to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Wara autopsy findings available prior to complation of ceusa of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

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physician a

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datachad tha signed by t

peeu has page 2

certificate funeral director,

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efter death.

To the Vithin 2

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Attending

6 Hospital c 24 hours e Funeral D

certificate be executed

Box 68760

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

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7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death a Department of Heelth and Mantal Hypiena. Important: If item 27 is marked other than "natural; or items 23a any injury or other treumatic event, the Medical Examiner mast.

Baltimore, Maryland 21215-0020

with the Maryland

Examiner Certification: To

Physician/Medical þ Completed Be

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was cesa rafarred to medicel axaminar? 1□ Yas 2□ 27. Mannar of Death

f Matural 2 Accident 5 Panding invastigation 6 Could not be 3 Suicida 4 Homicida

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year)

28b. Tima of

1 ☐ Yas 2 ☐ No 28a. Place of Injury - At homa, farm, straet, factory, offica building, atc. (Specify)

26. Placa of Death (Chack only ona) Other: 4 Sharsing Homa 5 Rasidance 6 Other (Specify)

28d. Dascribe how injury occurred

28f. Location (Streat and Number or Rural Route Number, City or Town, State) 15 Cortifying Physician: To tha bast of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar states.

(Check only one) 29b. Signaturar

29a. Cartifian

29c. Licansa number

28c. Injury at Work?

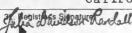
29d. Data signed (Month, Day, Year)

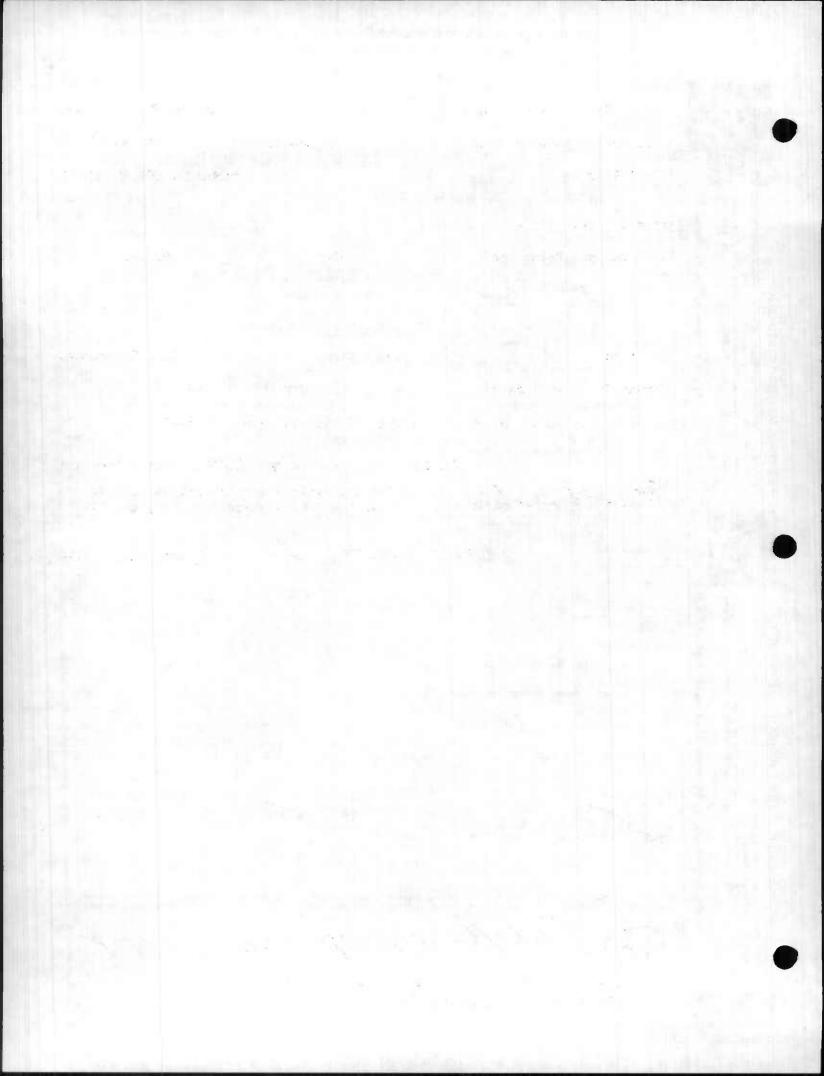
30. Nama and addrass of person who complated cause daath (Itam 23a) (Type, Print)

1998

David Allen, MD California, MD 20619

Registrar



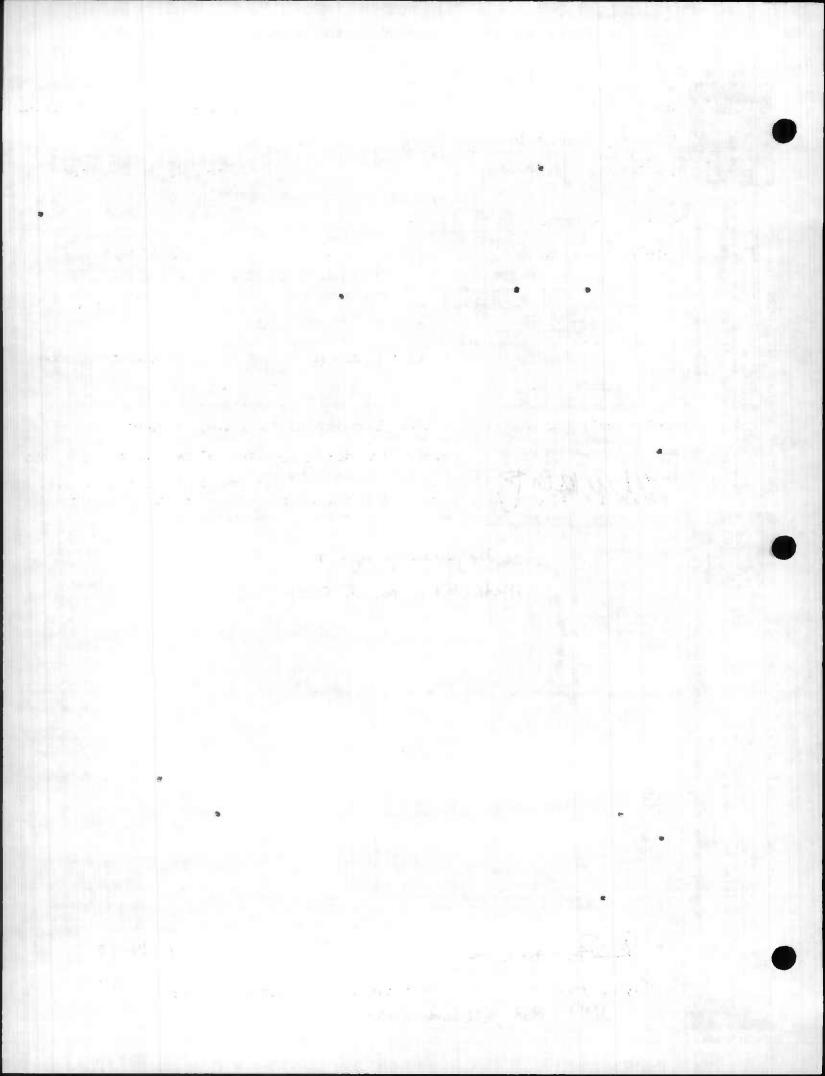


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State of Maryland / Department of Health and Mental Hygiene 9 8 0 2 7 4 0

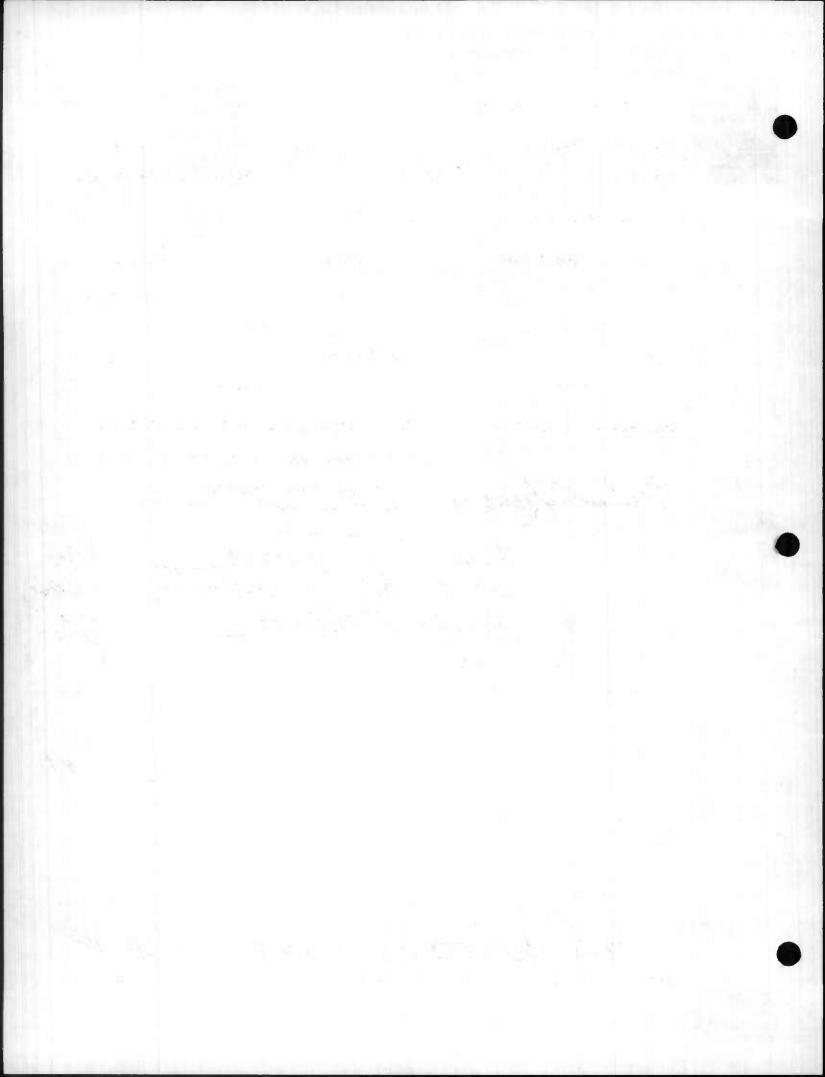
		eme (First, Midd	le, Last)	Tel Cal				2. Dete of Dec		Vari	3. Time of Deeth
Physiciar /Medica	- Danies	Gary	Hogan					January	^{Day} 23, 19	98	11:55 a.m
Examine	4e Fecility Nem	e (If not institution Highview	n, give street end no Circle	ım <i>ber)</i>			4b. City, Town, or Lusby	Location of Deeth	4c. County		
Funeral Director	5. Sociel Securit 040-24-0	•	6. Sex 1 ■ M 2 □ F	7. Age (In yrs. 67	lest birthdey) Yrs.	If Under 1 Yes Months Dey	r If Under 24 Hr		v Year)	Count	ece (Stata or Foreign ry) York
show	Usual Rasidano 10a. Stete	e of Decedant 10b. County	,	10c. C	ity, Town or Lo	cation				10	Od. Inside City Limits
death with the Meryland ms 23s or 28s-f show rmust be notified at	Maryland	Calv	ert	I	usby						1 ☐ Yes 2 ■ No
1 th	Maryland					10f. Zip Code			10g. Citizen of V	Whet Count	ry?
ath w	11810 H	ighview			10 10	20657		0 '4 - V N -	United	State	
Urs effer	3 □ Widowe	larried 2 Mer	Armed F	2 No		wes Decedent of f Yes, specify Cu 1 ☐ Yes 2 ■ N	Hispenic Origin? (ban, Mexican, Pue o <i>Specify:</i>	rto Rican, etc.)	Specify	ck, White, e	etc.
15.	(S Elamantary/S	15. Decedar pecify only higher econdary (0-12)	nt's Education est grede completed, College	(1-4or 5+)	(Give life. L	dant's Usuel Occ kind of work don DO NOT use rati	e during most of wa red)	orking	16b. Kind of Bu		
be filed tal Hygis d other event, t		ne (First, Middle			Clan	is Mariag		eme (First, Middle,			Company
Aaryland 2 should be filed and Mental Hygi is marked other eurmatic event,		Elihue	Hogan				Rose	e Eddy			
re, Maryland 212 s 1 end 2 should be filed withi theelth and Mental Hygiene. fem 27 is marked other than other traumatic event, the M	19a. Informant's		ship (Type, Print)				et end Number or F		er, City or Town,	State, Zip	Code)
1 end 1 Heelth em 27 l	Carol Be		ogan, Wif	20h	Place of Dispo	sition (Neme of	w Circle	Lusby,	Marylan 20c. Location -		
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Baltimore, In permit. Peges 1 end Department of Heelth Important: If Item 27 and Injury or other to page.		Funeral Service	A +			2. Name and Add	4 = 1 - 10	rinsfield			
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DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 98 0274 | Certificate of Death

hysician						mound	o or i	Death		Reg. No.		
		1. Decedent's Nama (First, Middla, L		5/4		17.4			2. Date of Date		Year	3. Time of D
/Medical	_	Wilhelm	Harde	er					January	7 25	1998	4:30 P
Examiner		e. Facility Nama (If not institution, g	ive street and numb	ber)			4	b. City, Town,	or Location of Deeth	4c. Count	y of Deeth	
	Ų.	St. Mary's Hosp						Leonard			Mar	
uneral	5	5. Social Sacurity Number 6.	Sex 7.		lest birthday)	If Under Months	1 Year Days	If Under 24 H Hours M		th y, Yaar)	9. Birth	place (Stata or I
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Funera Directo

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 64 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlet-transit

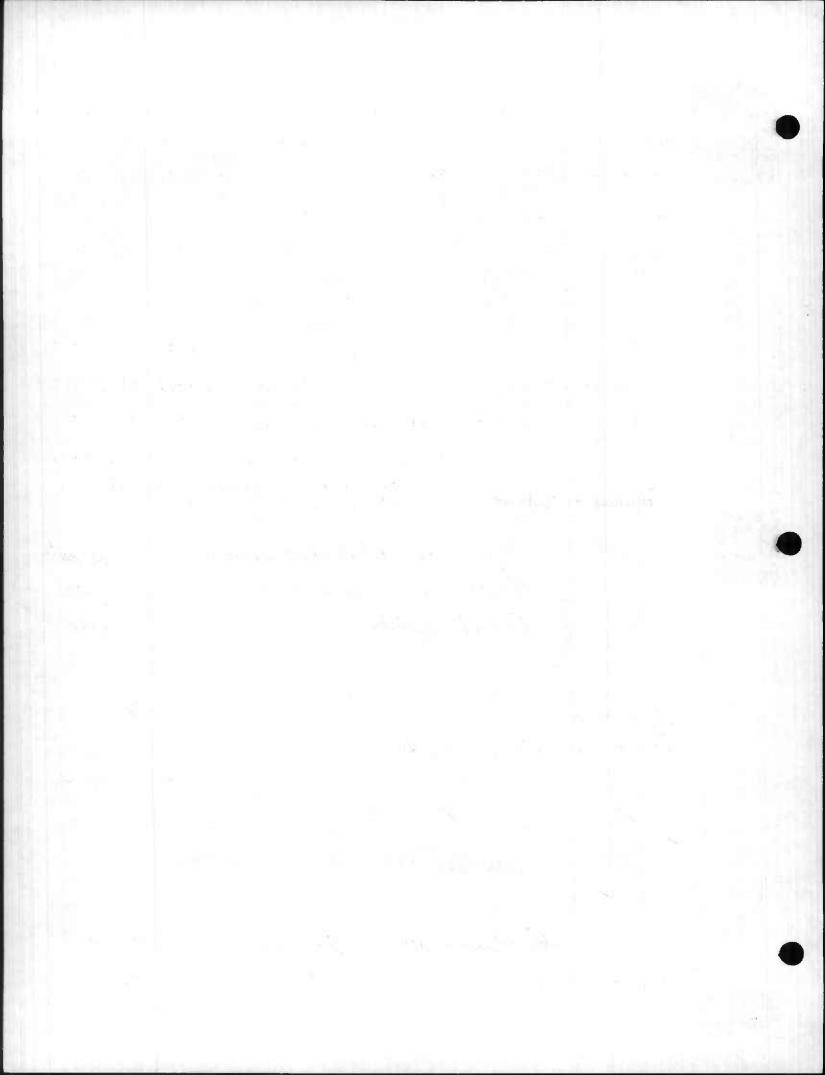
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

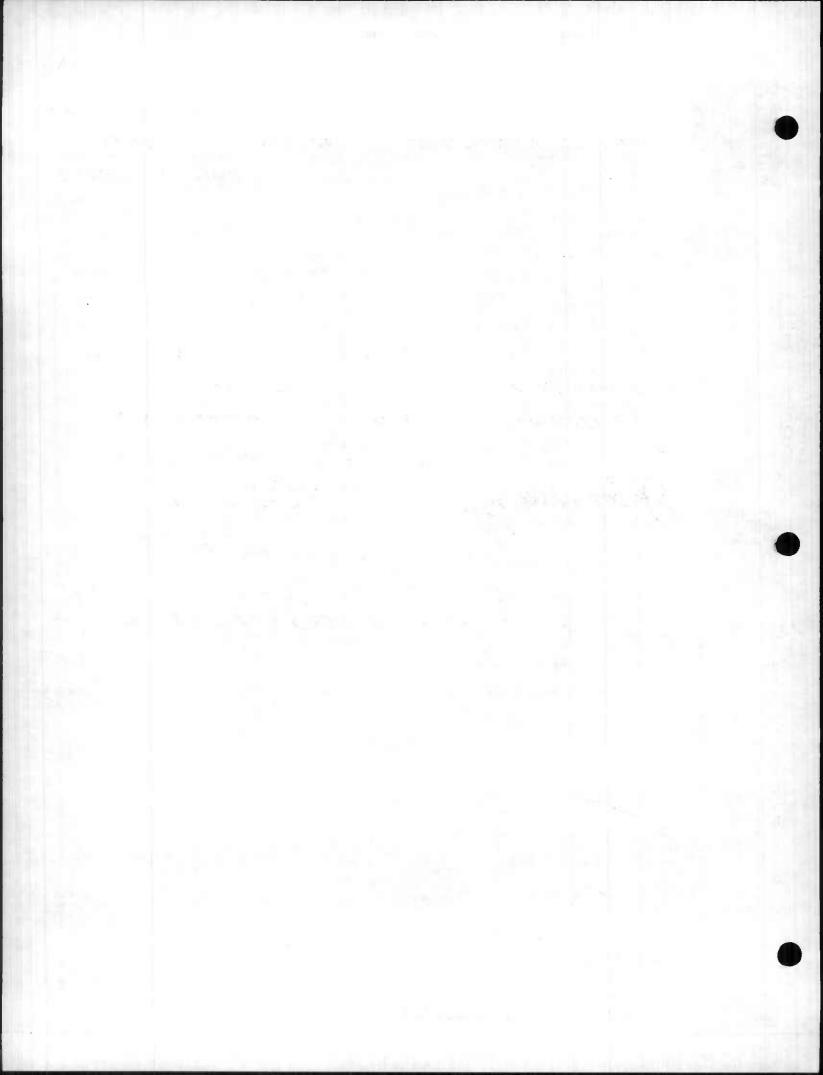
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by Fur	11. Marital Status 1 Never Marri 3 Widowed	ied 2□ Mar	12. Was Dec Armed F ried 1 X Yes	edent Ever In U		. Was Decedent of If Yes, specify Cut		Specify Yes or No- to Rican, etc.)	14. Ra Bla Speci	ice - Amerlack, White,	
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Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	ined Zee. Place	of Injury - At ho	ome, farm, s y)	treet, factory, office		28f. Location (S City or Tox		ber or Run	el Route Number,
edicai	29a. Certifier (Check only one)	Certifying	g Physician: To the Examiner; On the b and men	best of my kno- asis of examinat ner stated.	wledge, dee tion and/or I	th occurred et the ti nvestigation, in my	me, dete end plece opinion, death occu	e, end due to the curred et the time,	euse(s) end mate end place	nenner es s , end due t	steted. o the ceuse(s)
	29b. Signature and	title of certifie	MA	lower	910	29c. Licen	7-2593	33	29d. Date sign	ed (Month,	
	Michae	17.0	who completed cause	11 - D.	508	Idlewild	Ave, E	aston,	110211	601	
te ³	31. Date filed (Mont	th, Day, Year)	98	legistrer's Signa	dson-R	endell					



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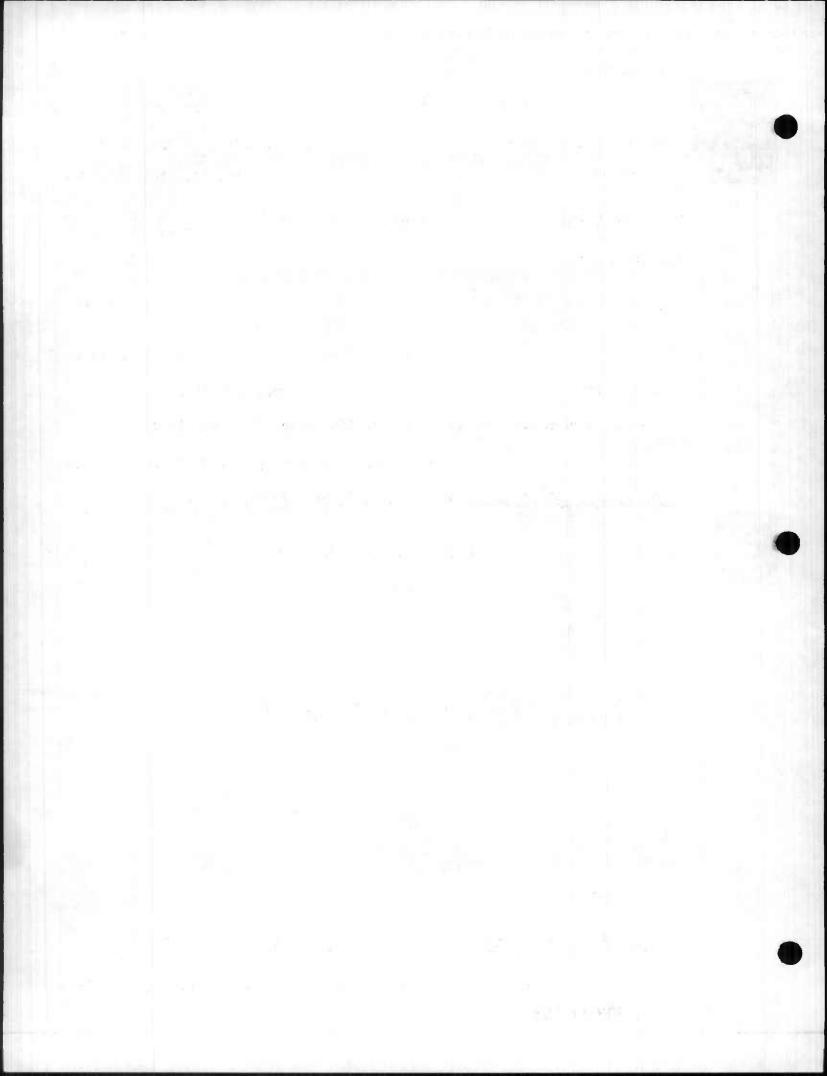
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PRINCIPLE STATE ST				WILLIAM	LEE		HA	RRIS		JANUA	LAY 1711	100	0041
Part Comment									4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
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e (Disease or injury nitieted avants ting in death) Lest	d		or as a conseq								
i. Other significant condition	ns contributing to de	ath but not ra	sulting in the u	ndariving	causa oiv	ran in Part I.	23b. Did	tobacco ua	e contribute	to the ca	suse of death
	The Contributing to do	attrout fut	saling in the a	nounying (Jausa giv	arriver arts.					4 ☐ Unknow
							24a. Was	en autopsy ormed?		vallabia complatio	prior to on of cause
							10	Yas 2K	No .	Yas	2 No
es casa raterred to medical						26. Place of De	eath (Check only	one)			
☐ Yas 2 No anner of Death Naturai 5 ☐ Panding	28a. Data o (Monti		28b. Tima of Injury	:	28c. injun Wor	y at k?				city)	
Sulcida 6 Could n	ot be 28a. Place	of Injury - At h	oma, farm, str fy)			140 2410			lumber or Ru	iral Route	Number,
Certifier 17 Certifying (Check only one) 21 Medical E	examinar: On the ba	sis of examina	owledga, daath ation and/or inv	occurred restigetion	at the tim	ne, data and piac pinion, death occ	a, and dua to tha surred et the time,	causa(s) en data and pi	d mannar as ace, and due	stated. to the ca	use(s)
Signatura and titla of conflier	Ar	カシ		29				29d. Deta s 1/19/	igned (Monti '98	n, Day, Y	ear)
1 00					MD	20679					
TA COCO	aminar? Yas 2N No Inner of Death Naturai 5 Panding Accidant Invastig Suicida 6 Could n datermi Certifier 17 Certifying Check only one) Identifier and title of coulder	aminar? Yas 2NNO Hospital: 1 I I I Inner of Death Naturai 5 Panding invastigation Accidant Sulcida 6 Could not be daterminad Certifier Check only 21 Medical Examinar: On the barend mann	aminar? Yas 2 No	aminar? Yas 2 No	aminar? Yas 2N No Hospital: 1 Inpatient 2 EP/Outpetient 3 Do not not possible invastigation Accidant Suicida Homicida Suicida Homicida Certifier Check only one) Madical Examinar: On the basis of examination and/or investigetion end mannar stated. Hospital: 1 Inpatient 2 EP/Outpetient 3 Do not possible invastigation 28a. Data of injury 28b. Tima of Injury M 28a. Place of Injury - At homa, farm, streat, tactor building, atc. (Spacify) 28a. Place of Injury - At homa, farm, streat, tactor building, atc. (Spacify) 29 Medical Examinar: On the basis of examination and/or investigetion end mannar stated.	aminer? Yas 2 No	aminar? Yas 2 No	es casa raterred to medical aminar? Yas 2N No	24a. Was en autopsy performed? Yas 2X	24a. Was en autopsy performed? 24b. y performed? 1	24a. Was en autopsy performed? 24b. Wara autovaliable in completic of death? 1

State of Maryland / Department of Health and Mental Hygiene

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/Med			JAMES	MILTON	IVINS	1	Jan.	19,	1998	1:10 A.M.
Exam	iner	4a. Facility Nama (If not institution, giv	A CONTRACTOR OF THE CONTRACTOR				own, or Location of	Death	4c. County of D	eath
		Corsica Hills (5. Social Sacurity Number 6. S		a (In yrs. last bir	thday) If Undar		treville		ueen An	
Funera Directo			TVM 20 F		Yrs. Months	Days Hours	Min. (Mon	of Birth th, Day, Ya 10,		Birthplaca (Stata or Foraign Country) Jaryland
show		10a. Stata 10b. County		10c. City, Tow	n or Location					10d. Insida City Limits
a-f si	ctor	Maryland Talbot		St. M	ichaels					1 ☐ Yas 2 No
다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다	Director	10e. Street and Number			10f. Zip	Coda		10g.	Citizan of What	Country?
23a		101 Miles Lane			216	63			U.S.A.	
15-0020 n 72 hours efter death with the Maryland •naturel; or items 23a or 28a-f show edical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Marriad 2 Marriad 3 Widowad 4 Divorced	12. Was Dacadant & Armed Forcas? 1 Yas 2 N If Yas, Giva A Yaar or Dates:		13. Was Deced If Yas, spec		rigin? (Specify Yas an, Puarto Rican, at ⁄:	or No- c.)	Black, W	marican Indian, /hita, etc. White
21215-0020 d within 72 hours of giena. In Medical Exam.	Pe	15. Dacedant's Ed	ducation	16a.	Decedant's Usua	I Occupation		16b	. Kind of Busina	
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arylan should be nd Mentel marked o	10	Harry Ivins					nreitta C			
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Heal Heal		James H. Barton	ı III Nepl		O. Box	398 Cent	reville,		and 21	671
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Baltim permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Spacify 21. Signature of Funeral Service Licer		Capito		tory Ja: d Addrass of Faci	n. 19, 19	98 I	over, D	elaware
Department of the part in the				,				omo l	Llama	
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		shock, or haart failure. List only	ona causa on aach lin	tha daath. Do i ia.	not antar tha mod	a or dying, such a	s cardiac or raspira	tory arrast,		Intarval Batween Onsat and Death
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68 / 60, ilicate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions	b	Dua to (or as a	consequence of):					100
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58 / 50, ifficate be ext	edical	Causa (Disaase or injury that initiated avants rasulting in daath) Last	c	Dua to (or as a c	consequance of):					
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v require	Completed						24a.	Was an e		b. Wara eutopsy findings available prior to completion of cause
a lew has t	mpi									of death?
Tha is the iceta he								1 🗆 Yas	2 1 No	1 ☐ Yas 2 ☐ No
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Pier Pier Pier Pier Pier Pier Pier Pier	Certification:	4 ☐ Homicida detarmined	building, etc.	. (Spacify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		or Town, S		
LIVISION O To the Hospital or Attending Ph within 24 hours eiter death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Cartifying Phyone) 2 Medical Exam	ysician: To the best of liner: On the basis of and manner stat	axamination and	, death occurred od/or invastigation,	et the time, dete e In my opinion, da	nd place, and dua t ath occurred at tha	o tha ceus time, date	a(s) end manner and place, and c	as steted. dua to the cause(s)
Vithir To the	Me	29b. Signatura and titla of parties	1 1-)		. Licansa numbar		29d.	Date signed (Mr	onth, Day, Year)
		MARIE	MO			4425	87	1	11919	8
		30. Name end eddrass of person who o	complated cause of de	eath (Item 23e)				-	/ /	
		Russell Sc	1. 1. 1. 1. M.	D/2 N	orth Lib	erty St.	Centrev	ille.	Marvla	nd 21671
St	ate	31. Data filad (Month, Day, Year)	32. Registra	r's Signatura	n-Randose					
Regis	trar	JAN 2 0 19	96 gul	ca Davidson	- Randell					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 10:50 Pm Nellie M. Isner 4e. Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Sandy Spring

ar If Under 24 Hrs. 8. Dete of Birth
Hours Min. 8. Dete of Birth
(Month, Dey, Year) Friends Nursing Home Montgomery If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 1□M 2⊠F Yrs 232-03-2199 Apr. 30, 1910 West Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Silver Spring Maryland Montgomery 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 10209 Green Forest Drive 20903 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Etementary/Secondery (0-12) College (1-4or 5+) 4 Secretary Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Irene Anderegg Otha Kent Isner 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Silver Spring, ryland 20903 10209 Green Forest Drive Norman N. Kerbel (brother-in-law) Maryland 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☑ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Elkins Memorial Gardens 1/18/98Elkins, West Virginia 21. Signeture of Funerel Service Licenses 22. Neme end Address of Fecility Francis J. Collins Funeral Home, Inc. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 500 University Blvd., W., Silver Spring, MD 20901 Approximete Intervel Between Onset end Deeth Immediete Ceuse (Final disease or condition resulting in deeth) HYPERTENSION Due to (or es e consequence of): HERNER WITH RECURRENT MERICAMINE HINTAL Due to (or es e consequence of): EHILE DEMENTIA

Baltimore, Maryland 21215-0020 Physician /Medical Examiner

attending physician and for use as the buriel-transit

signed by the a

certificate

To the Hospital or Attanding within 24 hours effer death.

To the Funeral Director: Afte completely filled in by the fun

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Completed

Be 0

Certification:

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Depertment of Health Important: If Itam 27 any injury or other ti

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Director

Funeral

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Completed

Be 2

Peges 1 end 2 should be liled within 72 hours after death with the Meryland nent of Health end Mentel Hygiene. Int: If Item 27 is marked other than "natural", or items 23e or 28e-f show

7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be

Sequentietly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest

Pert II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
		24e. Wes en eutopsy performed? 24b. Were eutopsy findings evallable prior to completion of cause of deeth? 1 □ Yes 2 No 1 □ Yes 2 □ No
25. Wes case reterred to medical	OC Place at Dooth //	
exeminer?	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DoA Other: 42 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Menner of Deeth 1 Neturel 5 □ Pending 2 □ Accident investigation	28c. Dete of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury et Work?	Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Pleca of Injury - At home, tarm, street, fectory, office building, etc. (Specify)	Location (Street end Number or Rural Route Number, City or Town, Stete)
29e. Certifier (Check only one) 152 Certifying Ph	/slclen: To the best of my knowledge, deeth occurred at the time, date and place, and there: On the basis of examination and/or investigation, in my opinion, deeth occurred and manner stated.	due to the ceuse(s) end menner es steted. et the time, dete and plece, and due to the ceuse(s)

29c. License number

29d. Dete signed (Month, Day, Year)

SILVER SPRING MD. 20905

State Registrar

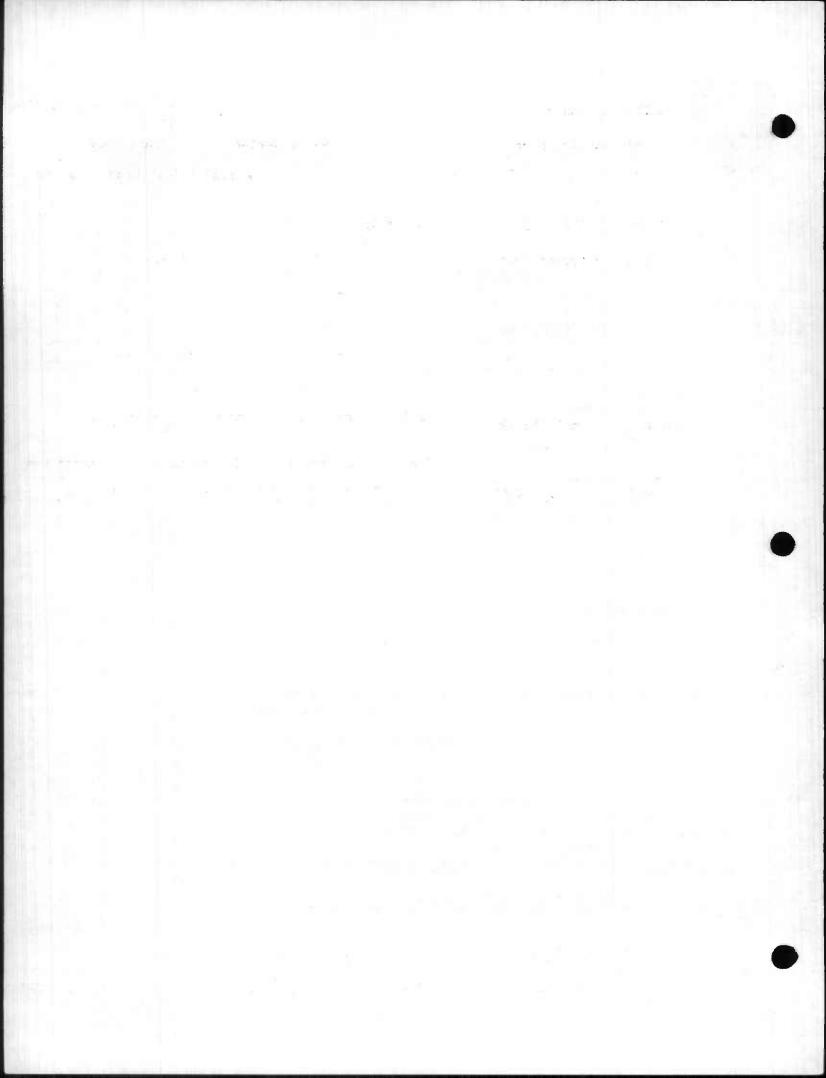
31. Dete tiled (Month, Day, Year) JAN 20

JOHN E. GLANCY III

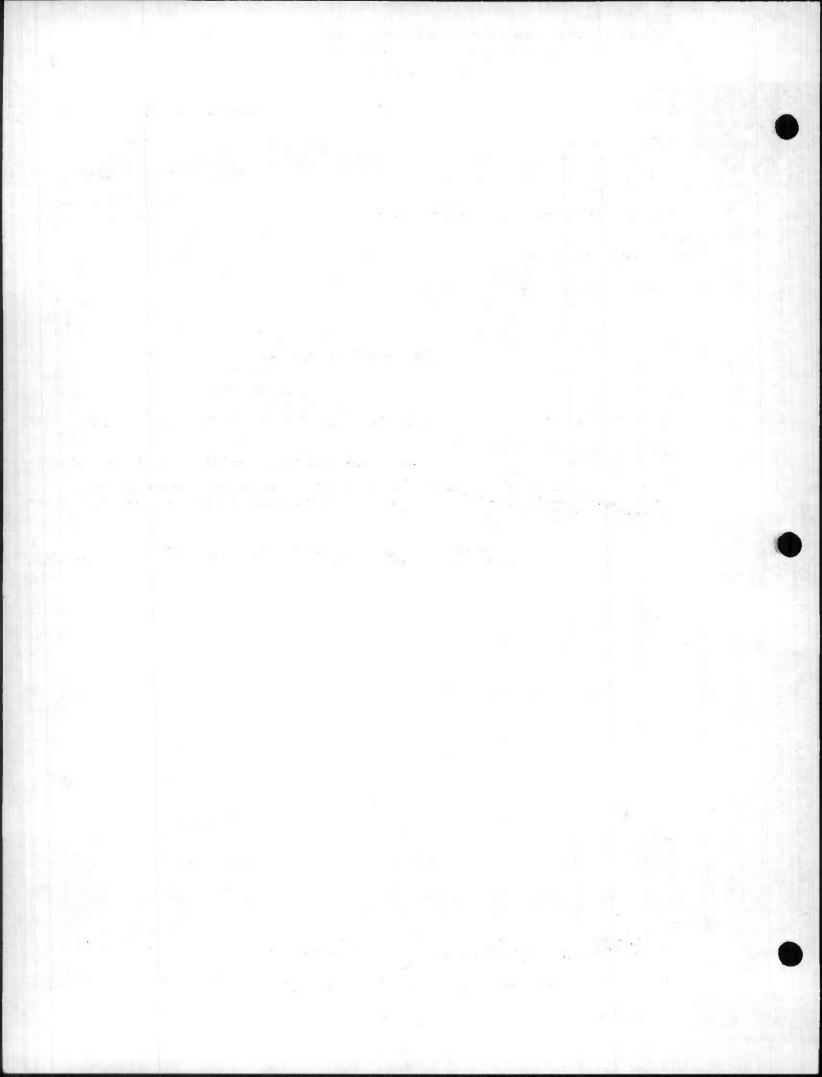
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29b. Signeture end title of certifier

733 CLOVERLY wo 32. Registrer's Signeture Julia Davidson



	1	Decedent's Neme (First, Mide	dla l'ace	1						2. Dete of D	Reg. No.		0.7	me of Deeth
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Examiner		. Fecility Neme (If not institution		street end nun	n <i>ber)</i>					or Location of Dee		County o		
	_	UBURBAN HOSPI' Social Security Number	6. Se		7. Age (in yr	c lone hire	thefore) If Uni	der 1 Yea	BETHESDA r If Under 24 H				OMERY	
Funeral Director	0	56-03-1759		XM 2□ F	7. Age (in yi		Yrs. Month						9. Birthplece (S Country) GEORGIA	tate or Foreig
š m		De. State 10b. Count	ty		10c. 0	City, Town	or Location						10d. Insi	de City Limit
nouthed at	M	ARYLAND MONTO	GOME	RY	CH	EVY (CHASE						1	Yes 2□N
or 28a-f a be numbed	10	De. Street end Number					10f.	Zip Code			10g. Citiz	en of W	het Country?	
al Die	3	713 UNDERWOOD	STR	EET			20	0815			USA			
free men	11	. Meritel Status		12. Was Dece Armed For		U,S.	13. Was De	ecedent of	Hispenic Origin?	(Specify Yes or Nerto Ricen, etc.)	0- 1-		- American India	an,
č.		1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		1 Ves Ch	2□No WW e ites: 1942	7 II 2-46		s 2 R No		and moon, etc.)		Specify:	k, White, etc. WH	ITE
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To	-	YER KATZ							SARA	ROCHMAN				
		9e. Informent's Name/Relation								Rurel Route Num				200
other to		ESTHER ISRALOW	/WII	E	004				JD STREE	T, CHEVY		-		
o o	20	e. Method of Disposition 1 □ Burial 2 □ Cremation	3 ⊡ R	emoval from S	State	cemetery	Disposition (f y, cremetory o	or other ple		Dete			City or Town, Sta	
any injury or once.		4 Donation 5 Other (KI	NG D				1/18/98	FALL	S CH	HURCH, V	IRGIN
ny ir	2	Signeture of Funeral Service	e Licens	1	-	-			ess of Fecility	G MEMORI	AL CH	APEI	S. INC.	
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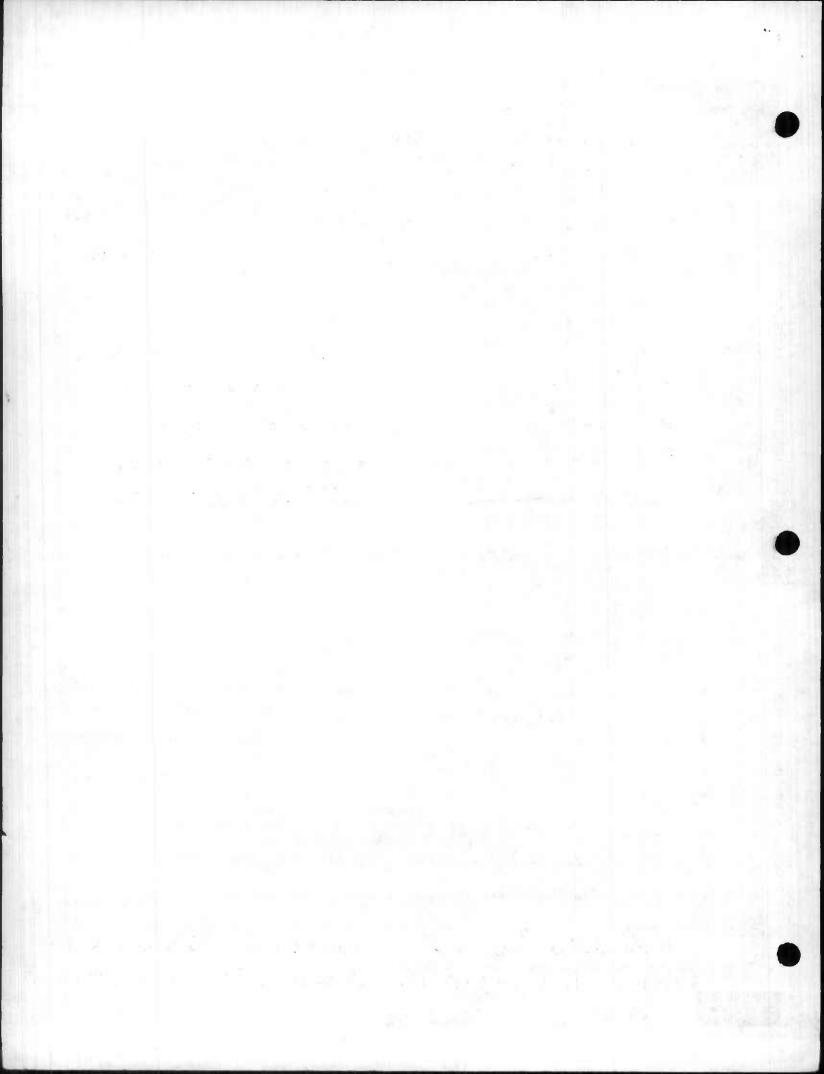


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Tima of Daath 2 Date of Death **Physician** 15 JOYNER VEZORES /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** HEARIZAND HYATTS VICLE HYATISVILLE If Undar 24 Hrs. 8 Data of 5. Social Security Number If Under 1 Yaar 9. Birthpiaca (Stata or Foraign Country) 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Months Deys Hours Min 79-36-5003 1 M 20 F Director WASH Usual Rasidence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Insida City Limits show Items 23s or 28s-f show Yas 2□No Director MD Prince George Suitland 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 3721 Woodsman Court 20746 United States Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ▼No If Yas, Giva Yaer or Dates: 13. Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Ricen, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status traumatic event, the Medical Examiner 1 X Never Marriad 2 ☐ Married 21215-0020 ŏ 1 Yes 2 No Specify: Black þ Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 15. Decedant's Education (Specify only highast grade complated) 16a. Dacedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working lifa. DO NOT usa ratirad) ef Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12th Staff Assistant Private Industry permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Itam 27 is marked othe any Injury or other trauments event Maryland 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Joseph L. Joyner Corrine Givens 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Baltimore, W Toni Green - Daughter 3721 Woodsman Court, Suitland, MD 20746 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State Data Burial 2 Cremation 3 Ramoval from State
4 Donation 5 Othar (Spacify) Forest Hills Cemetery 1/23/98 Clinton, MD 21. Signatura of Funaral Sarvice Licensea 22. Nama and Addrass of Facility R. N. Horton Co. Morticians, Inc.) forton 600 Kennedy Street, N.W., Wash., DC 20011 23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onset and Death **Physician** /Medical Immediata Causa (Final ARTERIOSCI FROTIC CARDIOVASCULAR DISEASE disaasa or condition rasulting in daath) Examiner Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury that Initiated evants rasulting in daeth) Last pue Dua to (or as a consequence of): burial-tran Box 68760 physicien Physician/Medical the i Due to (or as e consequanca of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco usa contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown esna Intarction þ The law requires 24b. Wara autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy performed? Completed Hypentension 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Attending Physician: 25. Was cesa raferred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Daath 28e. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? After 1 Hatural 5 Panding To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu NIA 1 ☐ Yas 2 ☐ No invastigation deeth 2 Accidant Could not be datarmined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 - Homicida 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian Medicai (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signature and titla of certifiar 30. Name end address of person who completed causa of death (Itam 23a) (Type, Print) 4203 Queensburgld Hyattsville MD20781 DEVORE MUD 32. Registrar's Signatura 31. Data filed (Month, Day, Yaar) State JAN 2 3 1998 Lula Savidson Randoll Registrar

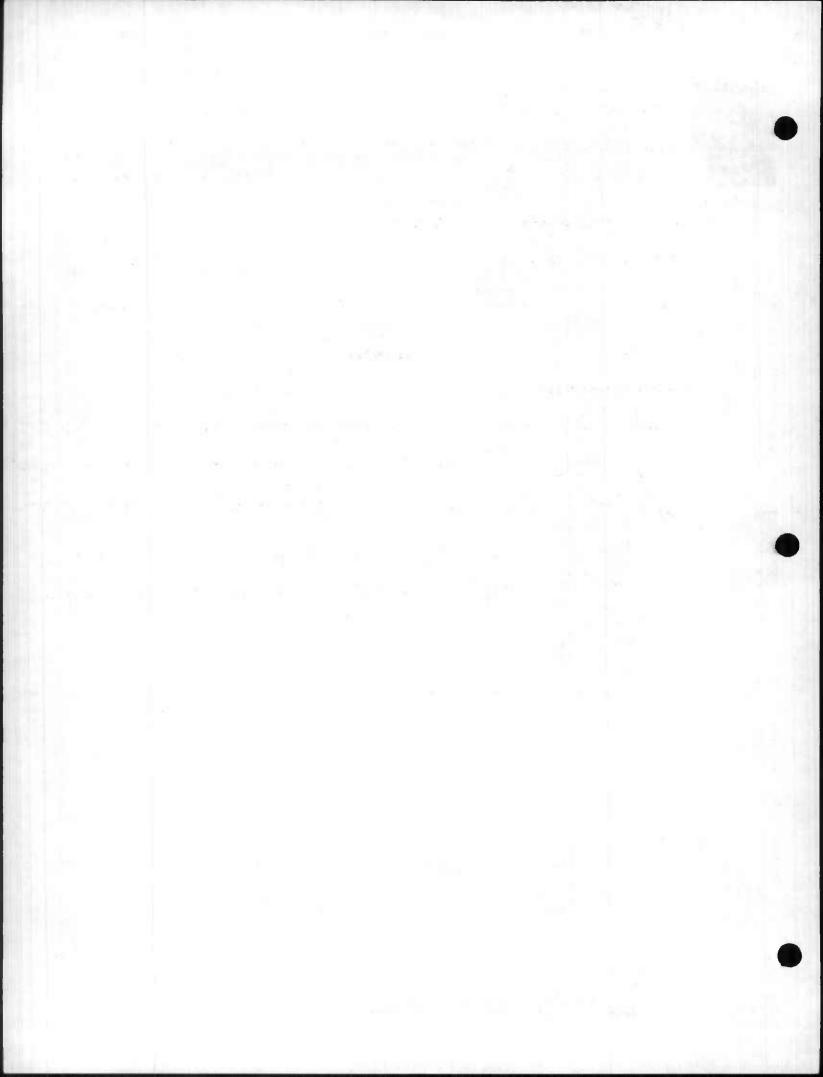


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State of Maryland / Department of Health and Mental Hygiene

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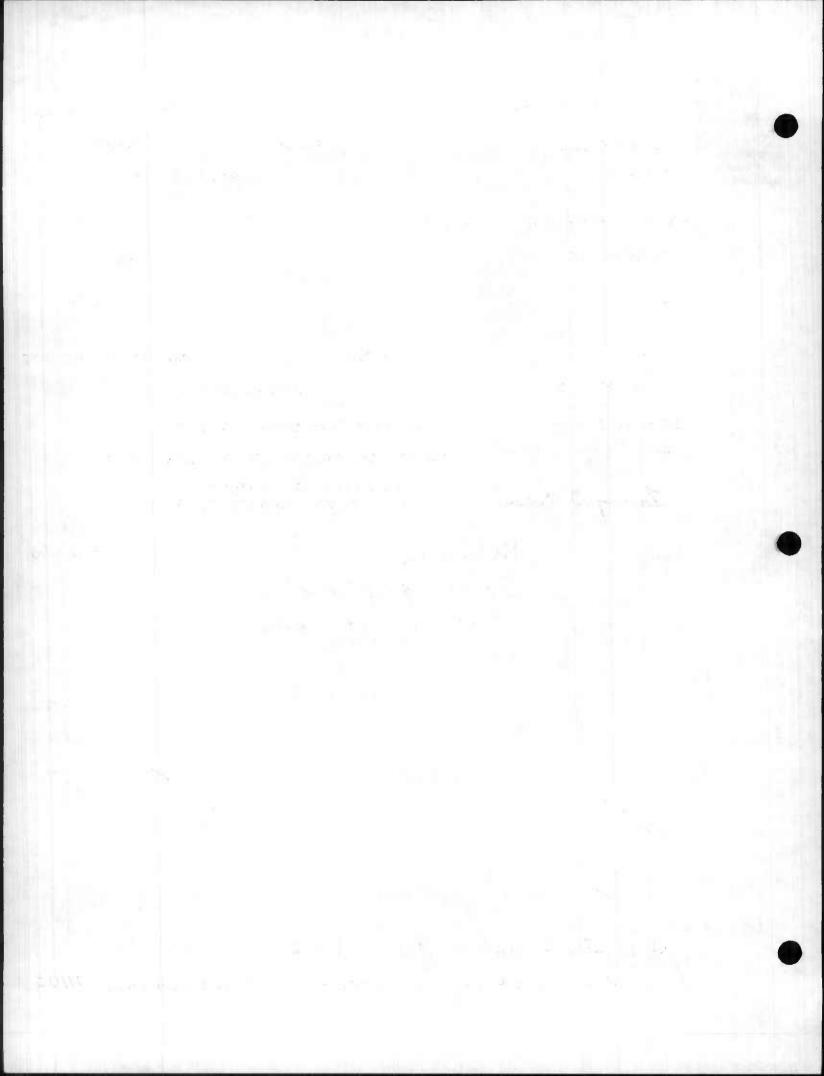


State of Maryland / Department of Health and Mental Hygiene

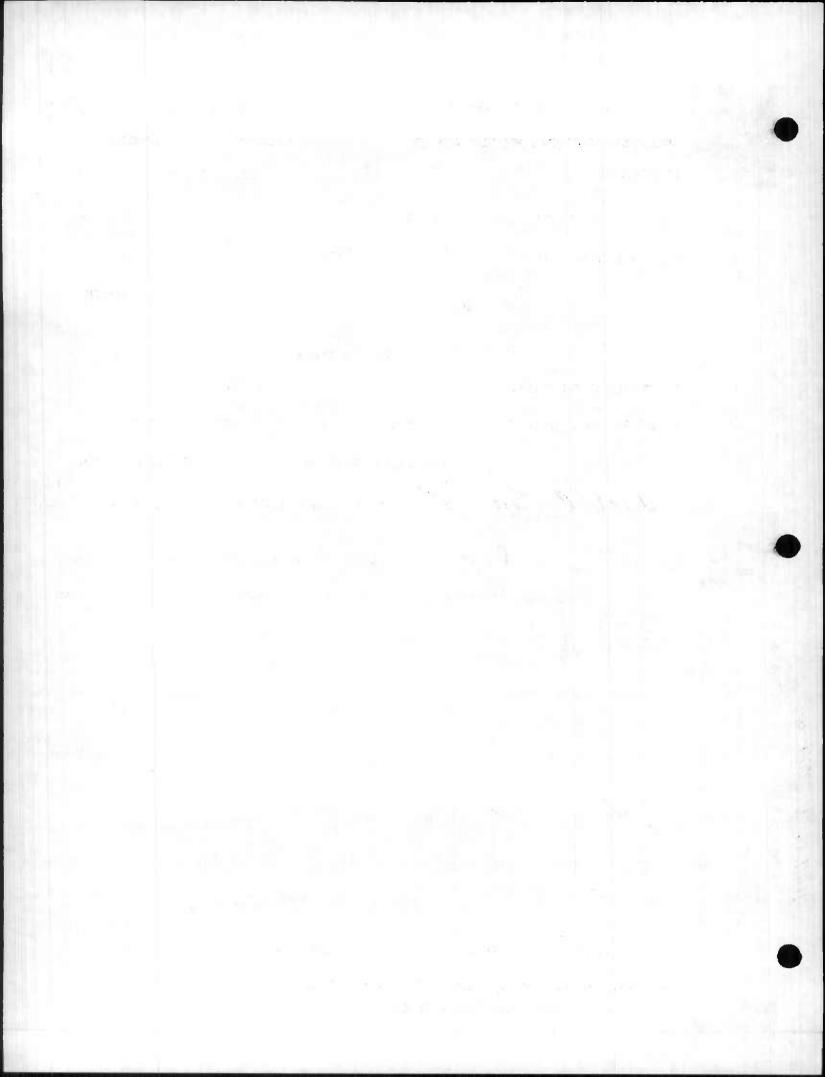
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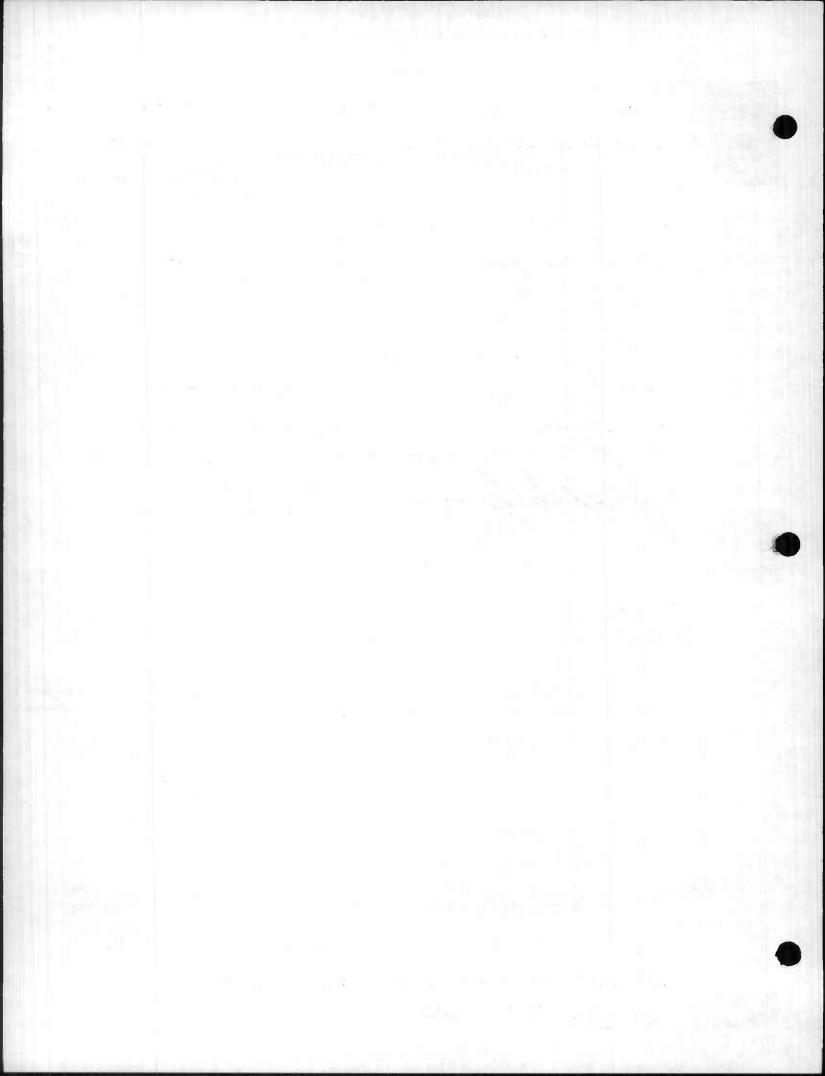
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/wedical Examiner	-	4e. Fecility Neme (If not institu	tion, give s	street end nu	n <i>ber)</i>				4b. City, T	own, or Lo	cation of Dee	4c. Cour	nty of Deeth			
	ı	PENINSULA REC	GIONA	L MEDI	CAL CE	NTER			SAI	LISBU	RY	WIC	OMICO			
uneral rector		5. Sociel Security Number 215–26–5368	6. Sex	(]M 2□F	7. Age (In yrs.	78 Yrs.	If Und Months	er 1 Year S Deys	If Unde Hours	Min.	8. Date of Bi (Month, D SEPT . 1	rth ey, Year) 2,1919	9. Births Cour	PA.		
3	-	Usual Residence of Decedent 10a. State 10b. Cour	ntv		10c C	ity, Town or Lo	ncation							I0d. Inside City		
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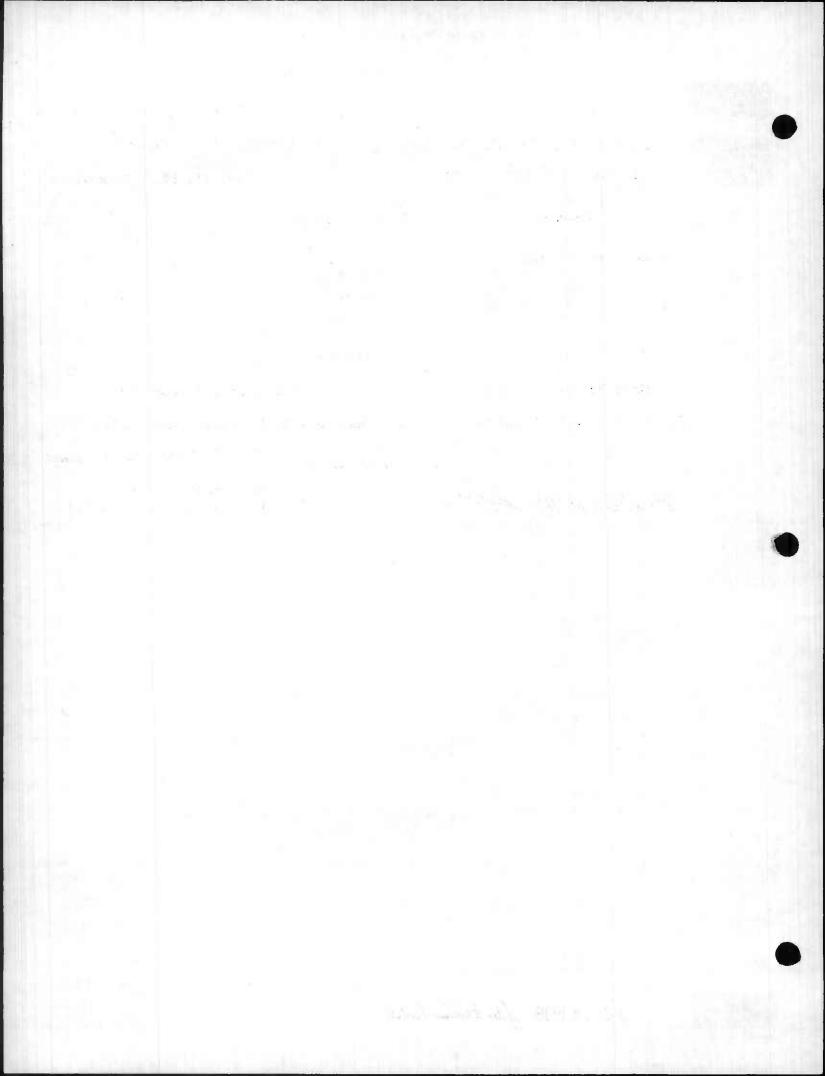


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day E. January 9, 1998 8:55 AM Eleanor /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Salisbury Center: Genesis ElderCare If Under 1 Year If Under 24 Hrs. Hours Min. Salisbury, MD Wicomico 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Days Yrs Director 177 14 7894 81 Jan. 31, 1916 Pennsylvania Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or itema 23a or 28a-f show traumatic evant, the Medical Examiner must be notified at Md Wicomico 1 ☐ Yes 2√ No Director Mardela Springs 10e. Street and Number 10f. Zip Code 10a, Citizen of Whet Country? with 1 21837 10290 Sharptown Road permit. Pagas 1 and 2 should be filed within 72 hours aftar death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Itema 23. any Injury or other fraumatic event, it was east any Injury or other fraumatic event, it was a set of the formatic event. Funeral USA 12. Was Decadent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: White 3 ♥ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Bender Mary Bender (Wiebrecht) 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Camille Bonniwell (Daughter) 10290 Sharptown Road Mardela Springs, Md. 21837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. 9 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, Maryland Cambridge Crematory 1998 21. Signeture of Funeral Servica Licansee 22. Name and Address of Facility Short Funeral Home 23a. Part1. Enter the disease, or complications that caused us shock, or heart failure. List only one cause on each line P.O. Box 204 Delmar, De. 19940 meth. Do not enter the mode of dylng, such as cardiac or respiratory errest, Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner ed by the attending physician and datached for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) Pert II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. Records. P.O. 23b. Did tobacco use contribute to the cause of deeth? signed by t 1 Yea 2 No 3 Probably 4 Unknown þ 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evailable prior to Completed peen completion of cause of death? has 1 ☐ Yes 2 ☐ No certificata Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) L_o 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Aftar 5 Pending Investigation 1 Naturel 2 Accident daath. 1 Tyes 2 No or Attend after death Director: 3 Sulcide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) fillad in by 4 ☐ Homicide 24 hours a Funerel D 29a. Certifier Medical 1 Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the ceuse(s) and menner es steted. To the Hosp within 24 ho To the Fune complately fi (Check only one) 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 1104 Healthway Dr., Salisbury, MD 21804 Dr. William Robins 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 14 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician EMILY JACKSON** 1998 2253 JANUARY 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT AND QUEEN ANNE'S HOSPITAL, INC. CHESTERTOWN KENT If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1□M 2 F Months Days Hours Director 220-26-1499 Nov.19 1920 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death v 127 Locust Street Funeral 21817 U.S.A 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: 3 Widowed 4 Divorced by natural', Black Be Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiana. Elementary/Secondery (0-12) College (1-4or 5+) 12 Domestic None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pagas 1 and 2 should be file Department of Health and Mantal Hy Important: If item 27 is marked oth any Injury or other traumatic evant once. 10 Wilbur Jackson Ethel McCready 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll Jackson (Niece) 23160 Club Terrace Chestertown, Md. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 16-97 Marion, Md. 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer Church Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Stewart Funeral Home 821 West Rd.Salisbury, Md.21801 Gladys B, Stewart 23a. Part1. Enter the didease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final 5 DIVA disease or condition resulting in deeth) Examiner Due to (or Examiner The law requires that the death certificate be axecuted Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last nding physician and use as the bunal-tran Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of) for P.O. ata has been signed by the page 2 should be datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 Yes 2 No Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificata 20 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director. Be 25. Was case referred to medical , 26. Place of Death (Check only one) Miner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 Inpatient 201 ER/Outpatient 3 DOA s efter death.

I Director: After this of in by the funeral di After this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: Division 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide Hospital 24 hours Medical 29a. Certifier Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

To the Hosp within 24 hor To the Fune completaly fi

(Check only one)

29b. Signature and title of certified

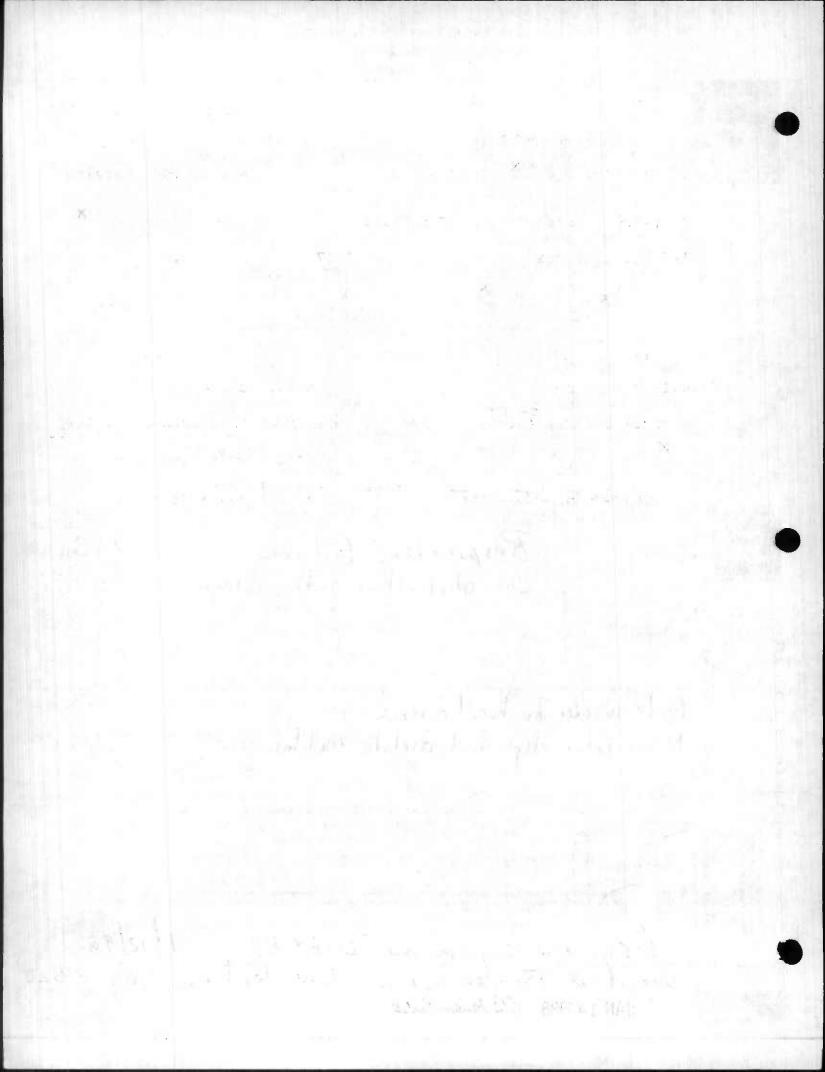
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of person who completed cause of deeth (Item 23e) (Type, Print) 30. Name and address enlanin JAY 31. Dete filed (Month, Day, Year)
JAN 14 1998

32. Registrar's Signeture July Durcless Randall

29c. License number

29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene \(\begin{align*} \begin{align*} \text{Proposition of Health and Mental Hygiene} \end{align*} \) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Kretzschmar Gertrud Ilse 1998 6:00 AM 21 Tan. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Talbot 25969 GOOSE NECK ROAD ROYAL OAK If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Numbar 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 10M 20X Deys Hours Yes 78 Director N/A MAR.3,1919 GERMANY Usuel Residence of Decedent 10b. County 10e Stete 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Director KAMPSTR, GERMANY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 38723 SEESEN/HARZ, GERMANY 38723 GERMANY 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. filed within 72 hours efter Hyglena. 1 ☐ Yes 2 No
If Yes, Give
Yeer or Detes: 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ◯ No Specify: WHITE Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7; Department of Heelih and Mental Hyglena. Important: if Item 27 is marked other than "na any injury or other traumatic event, the Mede once. Elementary/Secondary (0-12) College (1-4or 5+) 10 NURSE HEALTH CARE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumame) Be OTTO ADAM BERTA WACHTLER 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25969 GOOSE NECK ROAD, ROYAL OAK, MD 21662 GOTELINDE LEHMANN 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca)
CHESAPEAKE_CREMATION 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1 - 22CHESTER, MD CENTER, L.L.C.
22. Neme end Address of Fecility 21. Signeture of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Fine) diseese or condition resulting in deeth) Examiner ensios physician and the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence ot) Box 68760, Physician/Medical Due to (or es e consequence of) attending p isigned by the aid be detached for P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Dependent 1 Yes 2 No 3 Probably Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? peen certificate hes 2210 1 Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: 24 hours efter death. 25. Wes case reterred to medical examiner? Be 26. Pleca of Deeth (Check only one) Other: 4 Nursing Home See Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation Neturel efter death.

Director: After de in by the fur 1 TYes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eff To the Funeral DI completely filled in Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner steted. 29a. Certifier 29b. Signeture end title of contitier 29d. Dete sighed (Month, Dey, Year) 29c. License number 01/21/98 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Washington Sty Easton, MD 21601 Michael Lees, MD 219 South

State Registrar

JAN 2 2 1998



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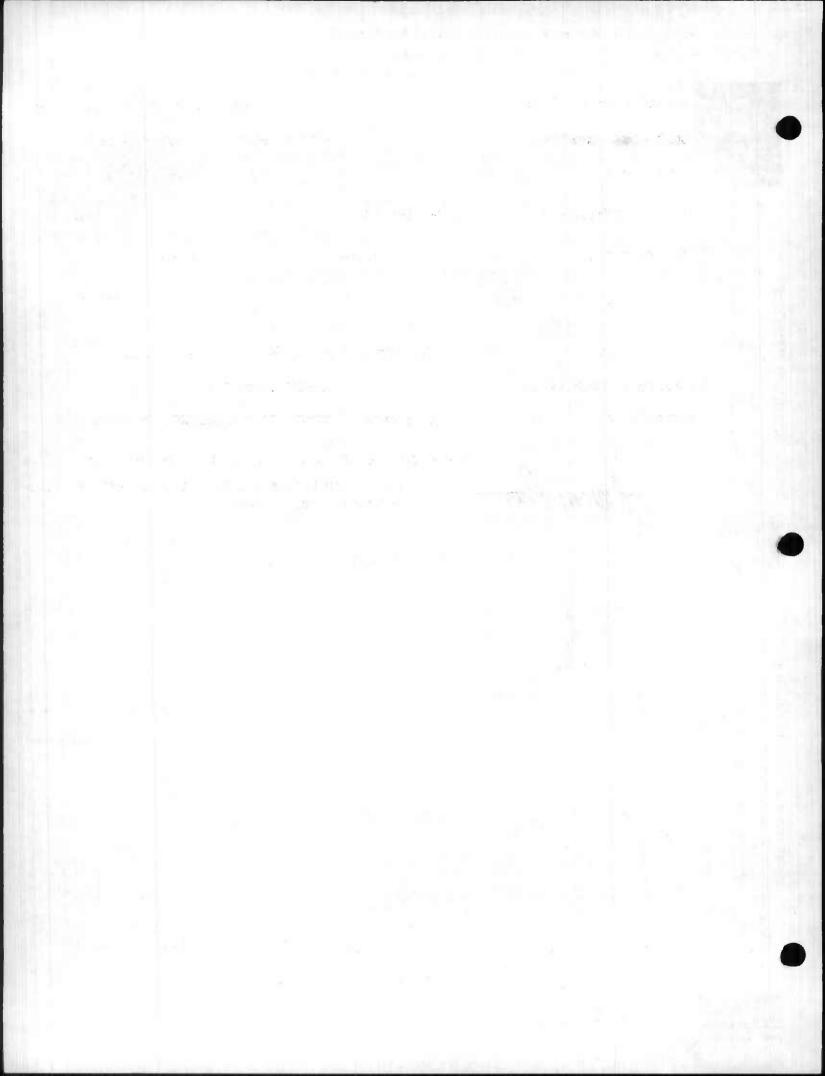
State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** MARION NORDLINGER KATZ 20, JAN. 1998 7:03 A.M. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Social Security Number If Undar 1 Year If Undar 24 Hrs. 8. Date of Birth Months Deys Hours Min. (Month, Day, 7. Aga (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Months 1 M 577-42-6523 Yrs MAY 6, WASHINGTON, D.C. 1936 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. Count 10d. inside City Limits 28a-f show r than "naturel", or items 23a or 28a-f show MD MONTGOMERY SILVER SPRING 1 XYas 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 2314 ROSS ROAD 20910 U.S.A. Funeral filed within 72 hours after death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ZNo If Yas, Giva 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Race - Amarican Indien, Black White, atc. 1 Never Married 2 ☐ Married Maryland 21215-0020 WHITE 1 Yes 2 No by If Yas, Giva Yeer or Dates: Specify 3 Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grede complated) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than " Elementery/Secondery (0-12) College (1-4or 5+) ADMINISTRATIVE PERSON REAL ESTATE al Hygie treumstic event. 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 12 should be fi end Mental H Is marked of BERNARD I. NORDLINGER JANET GREENTREE OL 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 st Depertment of Health end Important: If item 27 is in any injury or other treun ROBERT N. KATZ SON 2604 BAYWOOD COURT, SILVER SPRING, MD 20906 Baltimore, 20b. Plece of Disposition (Nama of camatery, cremetory or other place) 20c. Location - City or Town, Stele 20e. Method of Disposition 1 ☐ Buriel 2 X Cremation 3 ☐ Removal from Stata MOUNT COMFORT CREMATORY 1/22/98 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
JOSEPH GAWLER'S SONS, INC. 5130 WI AVENUE, N.W. cus WASHINGTON, D.C. 20016 23e. Pert1 Epier the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock of heart failure. List only one cause on each line. Approximete tntervel Between Onsat and Death **Physician** /Medical immediete Ceuse (Finel diseese or condition resulting in death) 84RS . METASTATIC BREAST CANCER Examiner Due to (or as e consequence of) Examiner that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of) Box 68760. ettending physiclan for use as the burie Physician/Medical Due to (or es e consequança of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by The law requires 24b. Were autopsy findings eveilable prior to complation of causa of deeth? 24a. Wes en eutopsy performed? Completed certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA this 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Pleca of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 4 - Homicide 24 hours a Hospital edical 29a. Certifier 15 Certifying Phyeicien: To the best of my knowledge, deeth occurred et the tima, date end place, and dua to the ceuse(s) end menner as steted. (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end mennar stated. within 2 To the F 29b. Signeture and tille of cartifier 29c. Licansa number 29d. Data signad (Month, Dey, Year) Tot JAN. 21, 1998 D17935 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) SANdS KENYON IRAN;

Registrar

31. Data filed (Month, Day, Yeer) 22

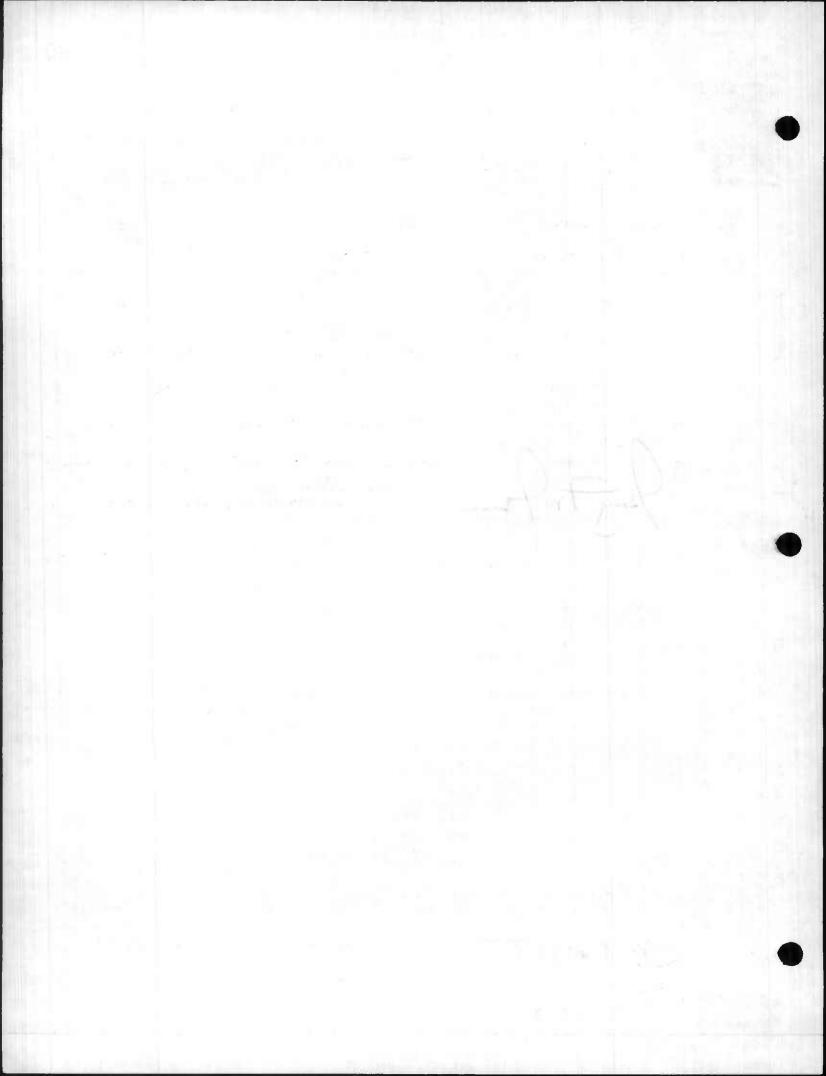
5530 WISCONSIN AVE.

#914 , CHEVY CHASE, MD. 20815 32. Registrar's Signature Solia Davidson



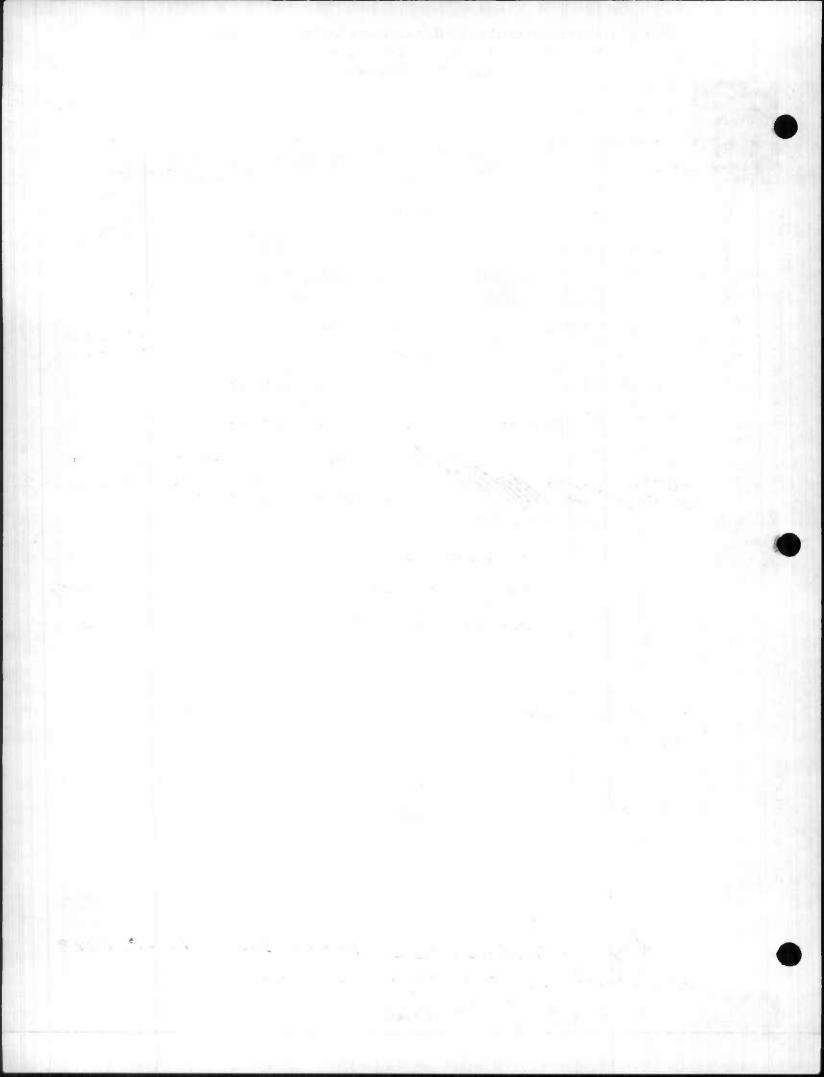
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Funeral Director		340-18-6588	Sax 1□ M 2√ F	7. Aga (In yrs 75			Months Da			(, Yaar)	9. Birthple Count Illi	aca (Stata ry) nois	or Foraigi
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		Warren Power	S					Ste	211a	Flynn			
		19a. Informant's Name/Relationship	(Typa, Print)		19b.	Mailing /	Address (Str	reet end Numbar or R	urel Routa Numbe	r, City or Town	own, Stete, Zip Code)		
them 27 in other tra		Terry Kernan, So	n					rford Stre	et, Derw	ood, MD	208	55	
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To the Funeral	29a. Certifiar (Check only one) Cartifying Phyaician: To tha best of my knowledge, deeth occurred at tha tima, 2 Medical Examiner: On the basis of examination and/or invastigation, in my opin and manner stated.								e, and dua to tha d urred et tha tima, d	ausa(s) end m late end place,	enner es ste and dua to	ited. tha cause	(s)
Toth	Ž	29b. Signatura and titla of certifiar	ansa number		9d. Data signa								
5		30. Name and address of person wh	end completed cause	of death (Ito	m 23a) /T	wne Dri-		5542 D	١. ٢.	1/18	-198)	
		Joseph P. Catl						, N.W., W	ashingto	n, D.C.			
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State of Maryland / Department of Health and Mental Hygiene 8

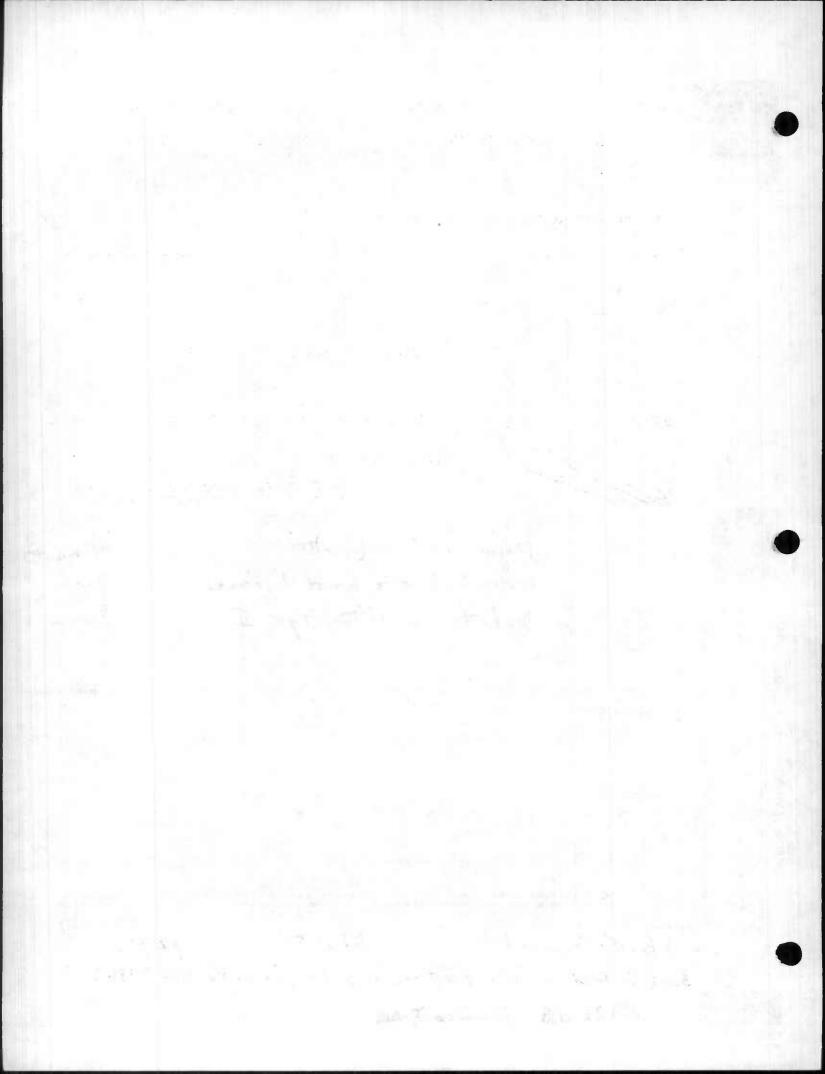
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/Medi		Sergey Khilko				1	4 0 T		ry 16,		6:18 P			
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Funeral Director		421-37-8014	. Sex 7. Ag 1	a (In yrs. lest l	Yrs. If U	nder 1 Year ths Deys	ace (Stete or Foraigr ry) ine							
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o with 72 hours enter death with the maryand infine Ithen "natural", or items 23a or 28s-1 show the Medical Examiner must be not the dat ompleted by Funeral Director		11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1			acedant of specify Cut s 2仰No	Hispenic Origin? (Sean, Mexican, Puer Specify:	Specify Yas or No to Rican, etc.)	Blac	14. Race - Amarican Indian Black, White, etc. Specify: White				
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than .	Completed	Elementary/Secondary (0-12)	College (1-4or 5		iile. DO NO		during most of wo		Nation Health/		stutute o			
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hysician		Ave. Silver Spring, MD 20904 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.												
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within To the comple	Me	29b. Signature hd title of certifier	29c. Licen	se number		29d. Dete signe	d (Month, E	Dey, Year)						
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		30. Neme end eddress of person wh Eugene Miknowski				gton,	DC 20036							
		Eugene Miknowski 1145 19th st. NW Washington, DC 20036 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature												



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** GEORGE KING JANUARY 19, 1998 11:45 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY Hours Min. 8. Date of Birth (Month, Day, MAY 29, 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer **Funeral** 9. Birthplece (State or Foreign 1 M 2 F Months Deys NEW YORK Yrs. 90 Director 087-18-6082 Usual Rasidenca of Decedent the Marylend 10e State 10c. City, Town or Location 10b. County 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MARYLAND MONTGOMERY ROCKVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9 6121 MONTROSE ROAD 20852 UNITED STATES Items 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Y Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indien, Black, White, etc. 11 Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural', or 1 Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Specify: WHITE Completed 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Dacadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiane. Elamentary/Secondary (0-12) Collaga (1-4or 5+) 4 FURNITURE SALES RETAIL 17. Fether's Neme (First, Middle, Lest) Be 18. Mother's Neme (First, Middle, Maiden Surnama) permit. Pagas 1 and 2 should be i Department of Haaith and Mental Important: If item 27 is marked or any Injury or other traumatic eve MOSES KOHEN 2 LENA KATZ 19a. Informent's Neme/Retationship (Type, Print) 19b. Malling Address (Streat end Number or Rural Route Number, City or Town, State, Zip Code) 2213 RICHLAND STREET - SILVER SPRING, MARYLAND 20910 LEONARD KING (SON) 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) WELLWOOD CEMETERY 1/22/98 PINELAWN, NEW YORK 21. Signature of Funeral Sa evice Licenses 22. Name end Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilura. List only one causa on each line. Approximete Intervel Between Onset end Death **Physician** /Médical Immediate Ceusa (Finel diseasa or conditio resulting in death) Examiner Examiner The law requires that the daeth cartificate be executed Sequentially list conditions, if eny, laeding to Immediate causa. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in deeth) Lest buriel-tran Box 68760, Physician/Medicai Due to (or es e consequence of) usa as tha P.O. I Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? bed by 1 Yee 2 No 3 Probably 4 Unknown Records, 2 page 2 should be Completed 24b. Were eutopsy findings evaileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? this certificata 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Be 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) 2 1 Yes 2 No Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA tha funeral 27. Manner of Deeth Data of Injury (Month, Day Year) Medical Certification: Aftart 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred or Attending 5 Pending investigation 1 Naturet after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) illed in by 4 Homicida To the Hospital within 24 hours a To the Funeral Complately filled Hospital 29a. Certifier tscrifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceusa(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D23958 diels 6105 Montrose Rd., Rockville, MD 20852 30. Neme end address of person who complated cause of daeth (Itam 23e) (Type, Print) MD Burt I. Foldman 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State JAN 21 Alia Savidson Registrar



State of Maryland / Department of Health and Mental Hygiene 8

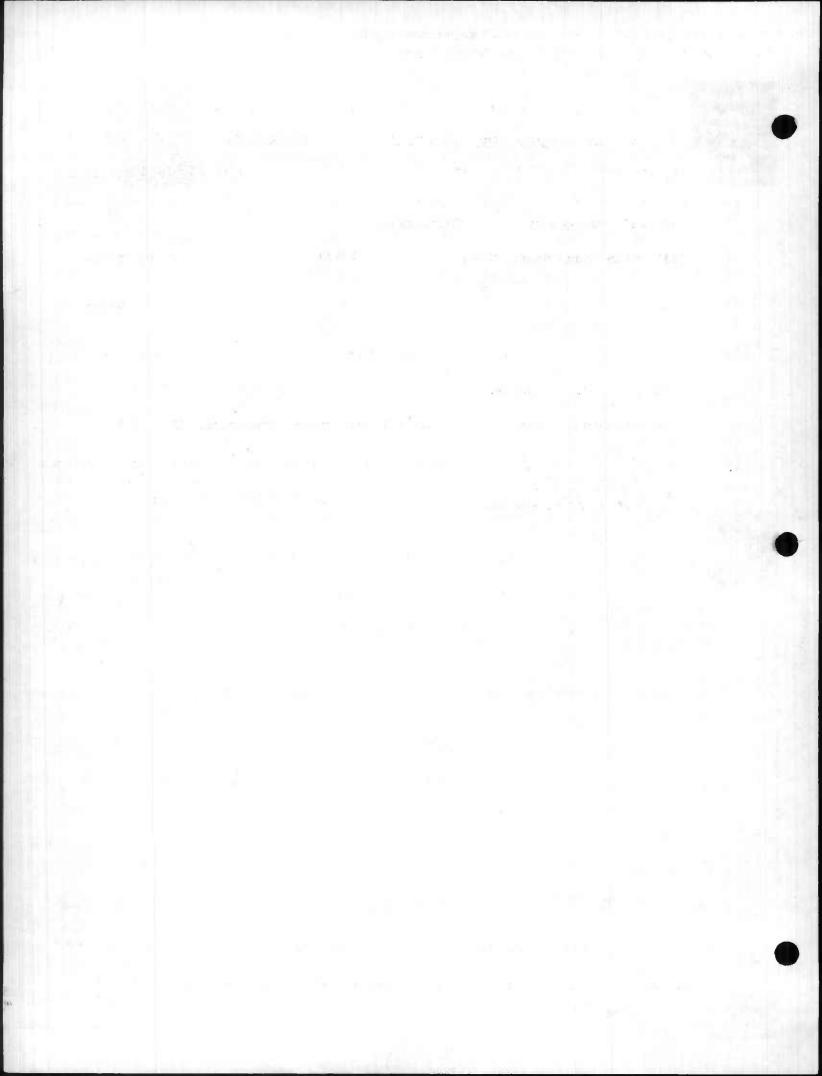
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ď	ă	Reuben O.	Jackson				Elizab		Flore				
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		Jack Kirshbaum,	Son		19b. Mailing Addrass (Streat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 8323 Sharon Drive, Frederick, MD 21704								
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State Registrar

S. Abulfarag, M.D., 481 N. Frederick Avenue, #230 Gaithersburg, MD 32. Pegistrar's Signatura

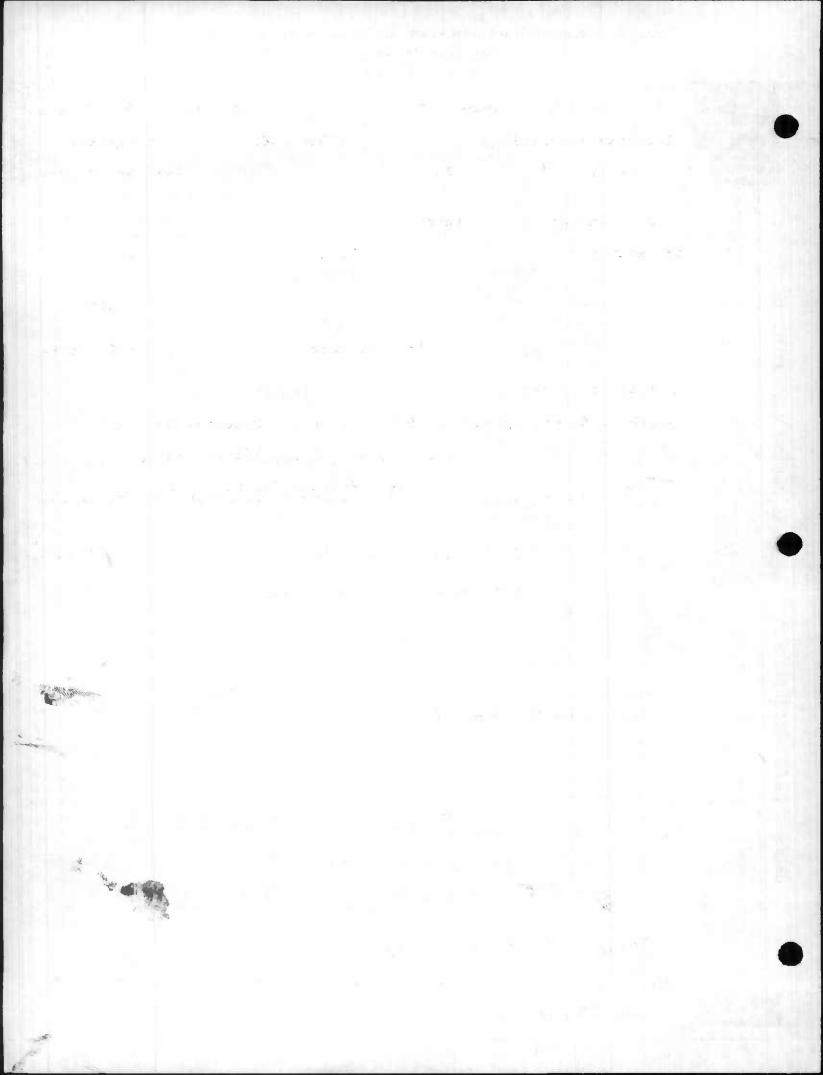
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30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 98 02761

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Physicia / /Medica		J. Leonard	Konigsb	erg						Januar	y 14,	1998	8:32	
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at of Health end Mental Hygiene. If terms 27 is marked other than "natural", or items 23s or 28s-4 show or other traumatic event, the Madical Evantiner maint be notified at	by Funeral Director	10e. Street and Number 190 Avenue B				10f. Zip	7 0 0	2		10	og. Citizan of U	What Coun	try?	
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end Men Is marked aumatic		19a. Informant's Name/Ralationship	(Type, Print)		19b. Malling Addrass (Streat and Number or Rural Routa						City or Town	, Stata, Zip	Coda)	
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of Health litem 27 r other tr		20a. Method of Disposition 20b. Place of Disposition (Nama of Data 20c. Location												
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Deeth **Physician** Month Day Kydd Donald 4:09 PM Russell 16, 1998 January /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 15823 Seurat Drive Gaithersburg | H Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | 9. Birthplace (State or Foreign Country) | 9. Birthplace (State or Foreign Country) | 9. Birthplace (State or Foreign Months Deys Hours Min. | Sept. 23, 1944 | 9. Birthplace (State or Foreign Months Deys Hours Min. | Sept. 23, 1944 | 9. Birthplace (State or Foreign Months Deys Hours Min. | Sept. 23, 1944 | 9. Birthplace (State or Foreign Months Deys Hours Min. | Sept. 23, 1944 | 9. Birthplace (State or Foreign Months Deys Hours Min. | Sept. 23, 1944 | 9. Birthplace (State or Foreign Months Deys Hours Min. | Sept. 23, 1944 | 9. Birthplace (State or Foreign Months Deys Hours Min. | Sept. 23, 1944 | 9. Birthplace (State or Foreign Months Deys Hours Min. | Sept. 23, 1944 | 9. Birthplace (State or Foreign Months Deys Hours Min. | Sept. 23, 1944 | 9. Birthplace (State or Foreign Months Deys Hours Min. | Sept. 23, 1944 | 9. Birthplace (State or Foreign Months Deys Months Deys Months Deys Min. | Sept. 23, 1944 | 9. Birthplace (State or Foreign Months Deys Months Montgomery 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 20 F 032-32-9650 Yrs 53 Director Usual Residence of Decedent the Maryland 10h County 10c. City, Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits 1 Yes 2 No Director Gaithersburg Maryland Montgomery 10e. Straat and Number 10f. Zip Code 10g. Citizen of Whet Country? 12403 20878 United States Gooderham Way Funeral death 12. Was Decadant Ever in U,S. Armad Forcas? 1 ☑ Yes 2 □ No If Yes, Give Yeer or Dates: Vietnam Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - Americen Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mentel Hygiene.
Int: If Item 27 Is merked other than "natural", or itee ury or other traumatic event, it a Medical Examination. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Specify: White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chemical Cleanup Manager 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be N. Leslie Gilchrist Raymond Kydd Mary 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) David N. Kydd (brother) 15823 Seurat Drive, Gaithersburg, MD 20878 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremetion 3 ☐ Ramoval from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) 1-18-98 Beltsville, Maryland Chesapeake Crematory 21. Signeture of Funeral Sarvica Licensee Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the diseasa, or complications thet caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final diseasa or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner that the death certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Lest Due to (or es e consequença of): physiclan s the buriel Physician/Medicai Dua to (or es a consequence of): 98 been signed by the a should be deteched t Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? Completed 24a. Wes an autopsy performed? page 2 1 ☐ Yes 2 No 2 NO certificate al or Attending Physician: T s efter death. Il Director: After this certificat funeral director, Be 25. Was cese referred to medicel exeminer? 26. Place of Deeth (Check only one) Brot rother Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 (X Naturel 1 Yes 2 No 2 Accident the 3 Sulcide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide To the Hospital
within 24 hours e
To the Funeral C
completely filled Hospital

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and nanner stated.

29c. License number

29d. Date signad (Month, Dey, Year)

State Registrar

Medicai

29a. Certifier

29b. Signature end tipe of cer

30. Neme end address of parson

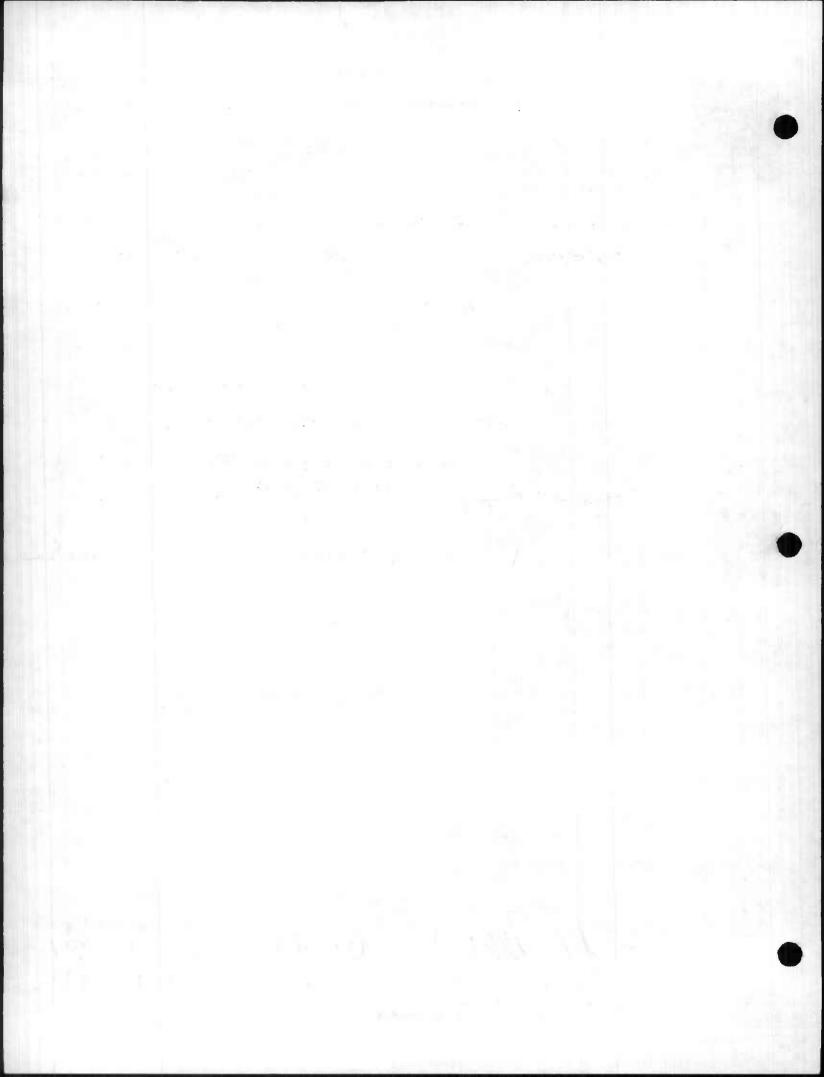
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Baltimore, Maryland 21215-0020

P.O. Box 68760.

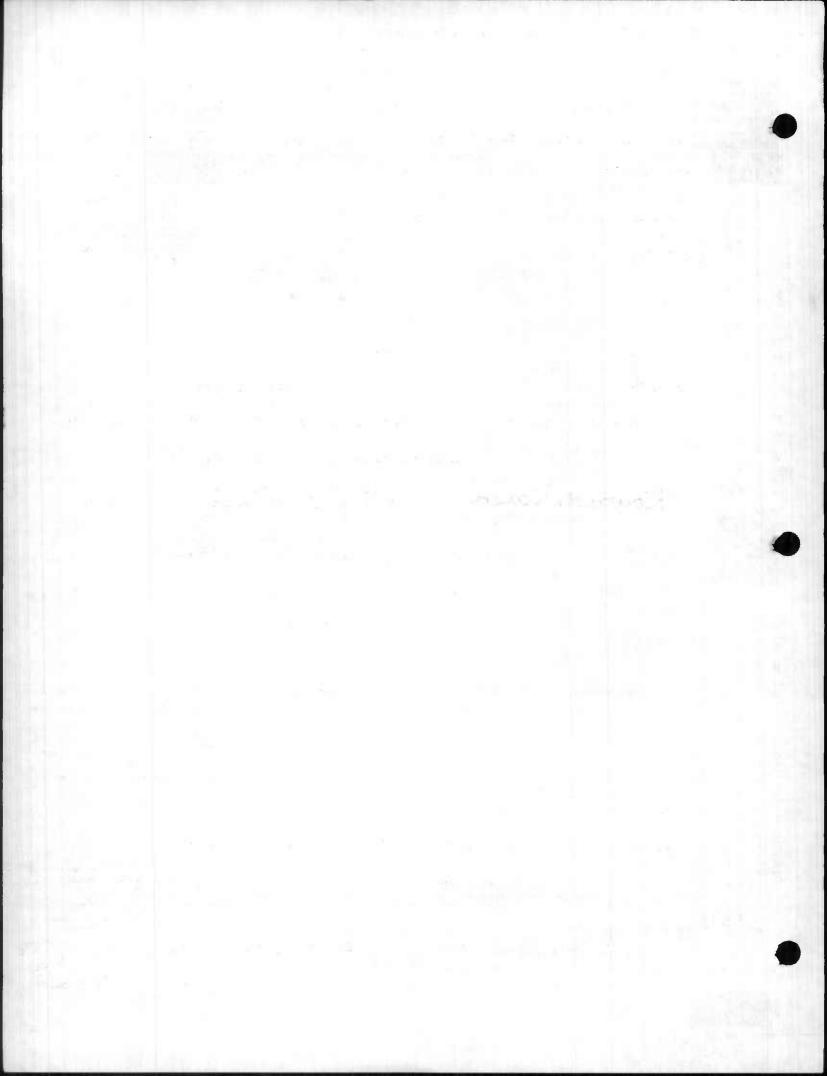
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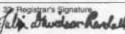
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Funeral Director	1	5. Social Security Number 284-09-0371 Usual Residence of Decedent	6. Sex 1 ☐ M 2/CXF	7. Age (In yrs 84	. last birth Y	Months	er 1 Yeer Days		4 Hrs. Min.	8. Date of Bir (Month, De Januar)	th ly, Year) y 30,19	9. Birth Cou 13 II	place (Stata or For ntry) Linois	
*=	1	10a. State 10b. County		10c. C	ity, Town	or Location							10d. inside City Lin	
28a-f show	0	Maryland Montg	omerv			Park							1 ☐ Yes 2 🔯	
28a	2	10e. Street end Number		10	Koma		ip Code				into/2			
ms 23a or 28a-f show	irai U	8020 Maple Aven					209				United of Am	l Stat merica		
er, or he	by rur	11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 □ Divorced	If Yes Give	ceş? 2 ZNo e	U,S.	13. Was Dec If Yes, sp		Hispanic Origi ban, Mexicen, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)		Race - Americen Indian, Black, White, etc. Brify: White		
"naturel", bulical Ext	Completed	15. Deceden	it's Education st grade complated)	10-0-0	16e. E	Decedent's Us	ual Occu	pation	of work in	20	16b. Kind of	Business/Ir	ndustry	
an "c	d.	Elementary/Secondary (0-12)	College (1	-4or 5+)	- '	lifa. DO NOT	use retire	during most (ed)	UI WUIKII	rg				
dien than	0	12			1	Homemal	ker				Own	Home		
d oth		17. Fether's Name (First, Middla,	Last)					18. Mother	's Name	(First, Middle	, Meidan Sum	ama)		
Mente arked stic s	0	John Urpi						Dagma	ar L	ehtone	n			
and s m		19a. Informant's Name/Relations	ship (Type, Print)		19b. l	Mailing Addres	ss (Stree	et and Number	or Rura	l Routa Numb	er, City or Tow	vn, Stata, Zij	p Code)	
oeith er tri		Carol Kilby/	Daughter		80	20 Map	Le Av	venue,	Tak	oma Pa	yland	20912		
Department of Heelith and Mental Hygiene. Important: if item 27 is marked other than instrument enert, the Medical once. To Re Completed	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of cematary, cramatory or other place) Over1ook Cemetery 2									Date 20c. Location - City or Town, State Parkman, 24, 1998 Ohio				
Depar Impor eny In		21. Signature of Funeral Service 23a. Part1. Enter the disease, or shock, or heart failure. List	Acais	an	ath. Do no	Mallo P.O.	bry-I Box	ess of Fecility Dehaver 252, Ging, such es ca	a Car	ettsvi:	lle, Oh	10 44	Approximate Intervel Between	
ysician Medical caminer		Immediate Cause (Finel disease or condition resulting in death)	e. O	and	e h					~	anch		Onset end Death	
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insit			b. —	ma	(or as a co	onsequence of):			120	ou ca	.00	Day	
el-transit	zaminer	Sequentially list conditions, if eny, leading to immediate	C b. F	ma	(or as a co	onsequence of):			120			Day	
oding physician end use as the buriel-transit	Medical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	b	Due to (or as a co	onsequence of): io			120			Day	
or use as the bur	Medical	resulting in death) Last	c	Due to (or as a co	onsequence of onsequence of): : : }:	tp					Day	
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State of Maryland / Department of Health and Mental Hygienes

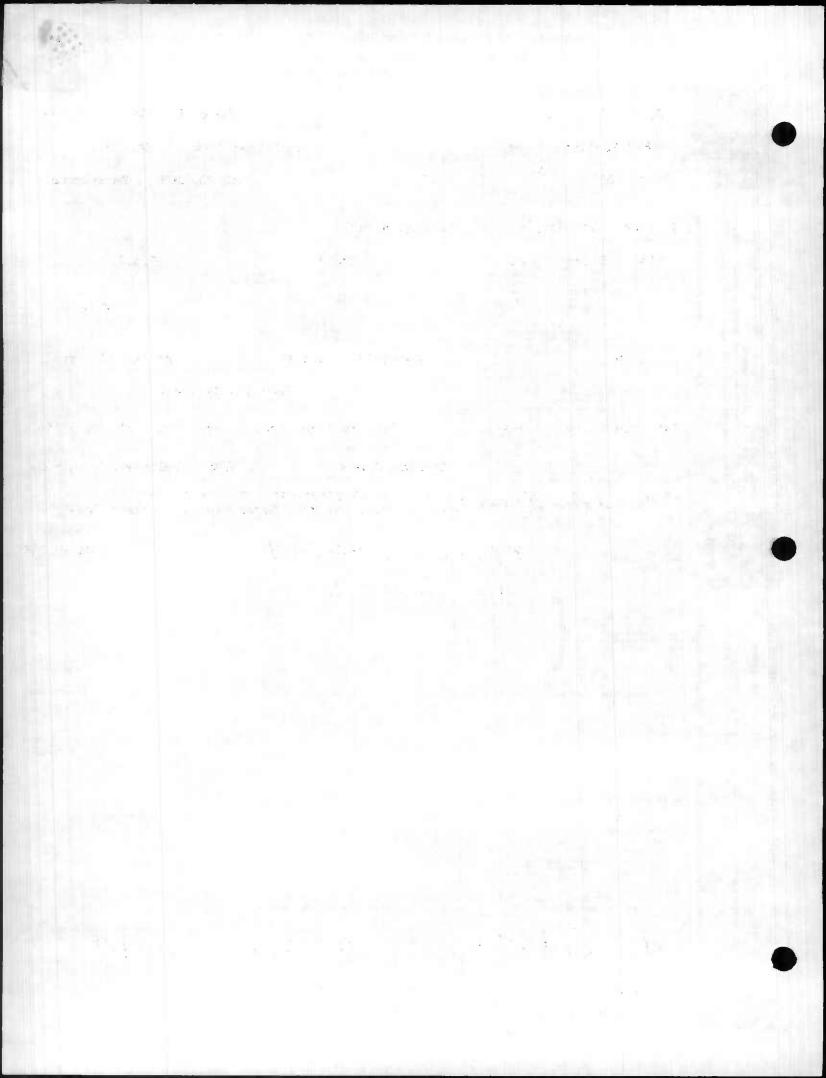
	1. Decedant's Nema (First, Middla, Last,					2. Data of Deeth		Vees	3. Time of Death				
Physician	Edward F. Kl	enke. Jr.				January	19, 19	Year 98	6:03pm				
/Medical Examiner	4a Facility Nama (If not institution, giva			4	b. City, Town, or Lo		4c. County						
LAdimine	Fairhaven Life C	are Community	v		Sykesvi	lle.	Carr	വി					
<u> </u>	5. Social Sacurity Number 6. Sec			f Undar 1 Yaar	If Under 24 Hrs.	8. Data of Birth (Month, Day,			ca (Stata or Forai				
Funeral Director		XM 2□ F 81	Yrs.	Months Days	Hours Min.	May 22,	1916	New					
23a or 25a-f show ust be notified at rai Director	10a. Stata 10b. County	10c. C	City, Town or Locat	ion				100	1. insida City Limit				
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or 2 Man Mo	10e. Street and Number			10f. Zip Coda		10	g. Citizan of V	Vhat Countr	y?				
ral las	C-137 7200 Third	Avenue			21784		U.S.A	۸.					
r Itsms 23. siner must Funeral	11. Marital Status	12. Was Dacedant Ever in Amed Forces?	U,S. 13. Wa	s Decedant of H	ispenic Origin? (Sp in, Maxican, Puarto	ecify Yas or No-		e - American k, Whita, at					
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H Page	Elementery/Secondery (0-12)	College (1-4or 5+)			ngineer								
	17. Fether's Name (First, Middla, Last)	4	CIR	allical F	18. Mother's Nam	a (First Middle N		_					
ked off	Edward F. Kle		Dieckmar										
N DE L	19a. Informant's Name/Relationship (Ty	al Routa Number,	coda)										
62.6	Mrs. Shirley E. K	ie Sykesy	rille	e, MD 21784									
Par Par	20a. Mathod of Disposition	Oc. Location -											
or in the state of	1 Burial 2 Cramation 3 F	amovel from Stata	Placa of Dispositi cematary, cramat	ory or othar plac									
any any	4 Donetion 5 Other (Specify)	C	arroll Ci	remation	Serv.	1/21/98 I	lampste	ead, MD					
Departiment important in anger	21. Signature of Funeral Service Licensea 22. Nama and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195 Sykesville, MD 21784 (410)-795-1400												
nysician	23a. Part1. Enter tha disaasa, or compl shock, or haart failura. List only or	ications that daused tha da na ceusa on each line.	ath. Do not antar t	ha moda of dyin	g, such as cardiac	or respiratory arra	st,		Approximete ntarval Between Onset and Death				
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si si si si si si si si si si si si si s)	(or as a consaqua	noa orj.									
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ng physician end as the burial-transit Medical Examin	Causa (Diseasa or Injury that initiated events rasulting in death) Last Due to (or as a consequence of):												
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ge 2													
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on the	27. Manner of Death 1 ☑ Natural 5 ☐ Panding 2 ☐ Accidant invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	M 1	yat k? Yas 2∐ No	28d. Describe ho							
s after death. If Director: A sd in by the fu	3 ☐ Suicida 4 ☐ Homicida City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Streat and Number of City or Town, Stata)												
within 24 hours af To the Funeral Di completely filled in Medical Cer		sician: To the best of my kiner: On the basis of axamic end mannar statad.											
Nethir	29b. Signatura end titla of certifier			29c. Licans		25	d. Data signe	d (Month, E	ay, Year)				
> = 0	· Roll 1.				2882		1/3	0/9	8				
	30. Nama and addrass of person who co	mpleted cause of death (It	om 22a) (Type Dri	int).	-	^	. 1						

Registrar



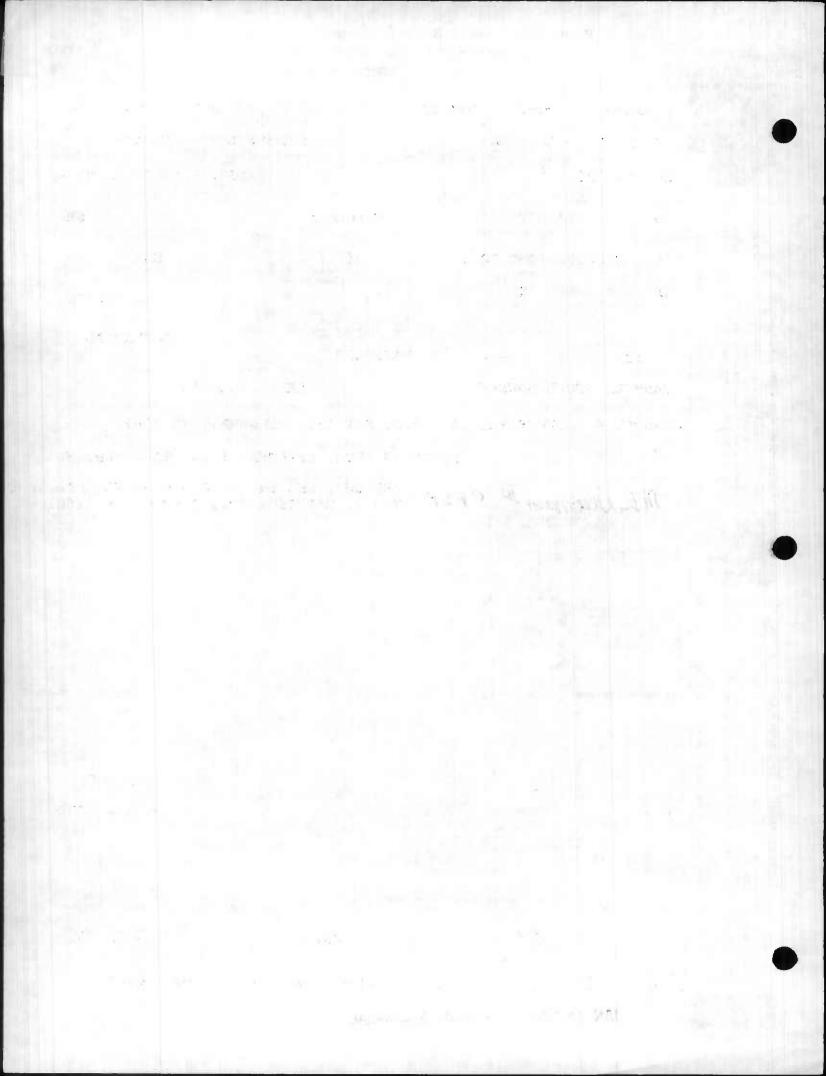
AND THE PERSON OF THE PARTY OF

		State of Maryland / Department of Health and Certificate of Death		ien'e) 8 U og. No.	2100
		Decedent's Name (First, Middle, Last)	2. Dete of Death	h	3. Time of Death
	Physician /Medical	Iomaa Michael Valla	Month January	Dey Yeer 13, 1998	9:15 PM
	Examiner	4n Caritie Alama (16 and incitivation aire attack and number)	or Location of Death	4c. County of Dec	
			gton Park		lary's
	Funeral	IDIM 2LF	lin. 8. Date of Birth (Month, Day,	Year) 9. Bi	irthplece (Stete or Foreign Country)
٠.	Director	186 - 32 - 0855 58 Tis.	July 23,	1939 Per	nnsylvania
	show	10e. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
	with the Meryland a or 28a-f show be notified at	Maryland St. Mary's Lexington Park			1 Yes 2 No
	or 2	10e. Street and Number 10f. Zip Code	10	Og. Citizen of Whet C	Country?
	me 23a	20843 Sunlight Court 20653	(Specify Ven er No	U.S.A	
Maryland 21215-0020	urs efter al', or its Examine hy Fin	If Yes, Give 3 □ Wildowed 4 □ Divorced Yeer or Dates:	erto Ricen, etc.)	Bleck, Wh	
2-0	ed within 72 ho ygiene. her than "natur. it, tre Medical	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of		16b. Kind of Busines	
2	within one.	Elementery/Secondery (0-12) College (1-4or 5+)	working .		
2	Hygiene the the the	12th Operations Manager		Paint In	ndustry
and	3 5 5 0 C		Name (First, Middle, N		
2	d 2 should be the and Mentel 7 is marked o traumatic eve		y Ann Kavai		Pin Cadal
Ma	d a d a d a d a d a d a d a d a d a d a	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number of Print) 19c. Informant's Name/Relationship (Type, Print)			
e,	He He	Kathleen Kelly Spouse 20843 Sunlight Cou		gron Park, 20c. Location - City of	
JOE NO	Pege ht: If I	1 XBurial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Servicing Competers:	1/17/00	OI 1. 1	
Baltimore,	- 독특류 .	21. Signeture of Funeral Service Licensee Sepulchre Cemetery 22. Name end Address of Facility	1/17/98	Uneltennam,	Pennsylvania
B	Depe Impo	Mechael Leven Hordiner Mattingley-Gard			
		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care	eonardtown- diac or respiretory erre	At, Maryland	d 20650 Approximete
J	Physician	shock, or heart failure. List only one cause on each line.			Interval Between Onset and Deeth
	/Medical	Immediate Ceuse (Finel disease or condition CARDIOMYOPATHY			SEVERAL YRS
	Examiner	resulting In deeth) Due to (or es e consequence of):	(
	B : 2	Immediate Ceuse (Finel disease or condition resulting In deeth) e. CARDIOMYOPATHY Due to (or es e consequence of): HIS HYPERTENS(0)	J		
	be executed ician and buriel-transit				
8760,	cate be execut physician end s the buriel-tran	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Undertying Cause (Disease or Injury that initiated events			
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Box	ettending particular de es	d			
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P.0	that the dead by the detached	t at it. Other significant continue continuency to death out not resolving in the underlying cause given in the fit.			Probably 4 🛭 Unknown
	igned in be det				
of Vital Records,	v requires that the death certific been signed by the ettending pshould be detached for use es letted by Physician/Men		24e. Wes ar		b. Were autopsy findings aveileble prior to
00	> 0 0		- 1		completion of cause of deeth?
E E	The law require sets hes been signed as should Completed		1 ☐ Ye	es 2 X No	1 ☐ Yes 2 ☐ No
/ita	iclen: The lav certificate hes rector, page 2	25. Was cese referred to medical 26. Plece of	Death (Check only on	е)	
) t	hya his	1 Yes 20 No rospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursin	g Home 5 X Reside		pecify)
NO.	gr iffe o	27. Manner of Death 28e. Dete of Injury 28b. Time of Work? 28c. Injury et Work? 1 1 Neture 1 investigation M 1 1 Yes 2 No	28d. Describe ho	ow Injury occurred	
isio	Attending or deeth. ector: After by the fune iffication	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined between the country of the determined state of the country of the c	28f Location (St.	reet and Number or	Rural Route Number,
Division	tal or Attending Pins after deeth. al Director: After tiled in by the funera Certification:	4 Homicide determined building, etc. (Specify)	City or Town	i, Stete)	
	spital neral / fillec		ace, end due to the ce	suse(s) end menner	es steted.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi Medical Certificati		courred et the time, de	end plece, and d	ue to the ceuse(s)
	To the To the Community of the Community		7	9d. Dete signed (Mo	onth, Dey, Year)
		Jun 19 4059	>	1/14/9	18
		30. Name and eddress of per un who completed cause of deeth (Item 23a) (Type, Print)			
		A. K. Shah, MD. Hollywood, MD 20636			
	State Registrar	31. Dete filed (Month, Day, Year) JAN 20 1998 32. Registrar's Signeture Author Randall			



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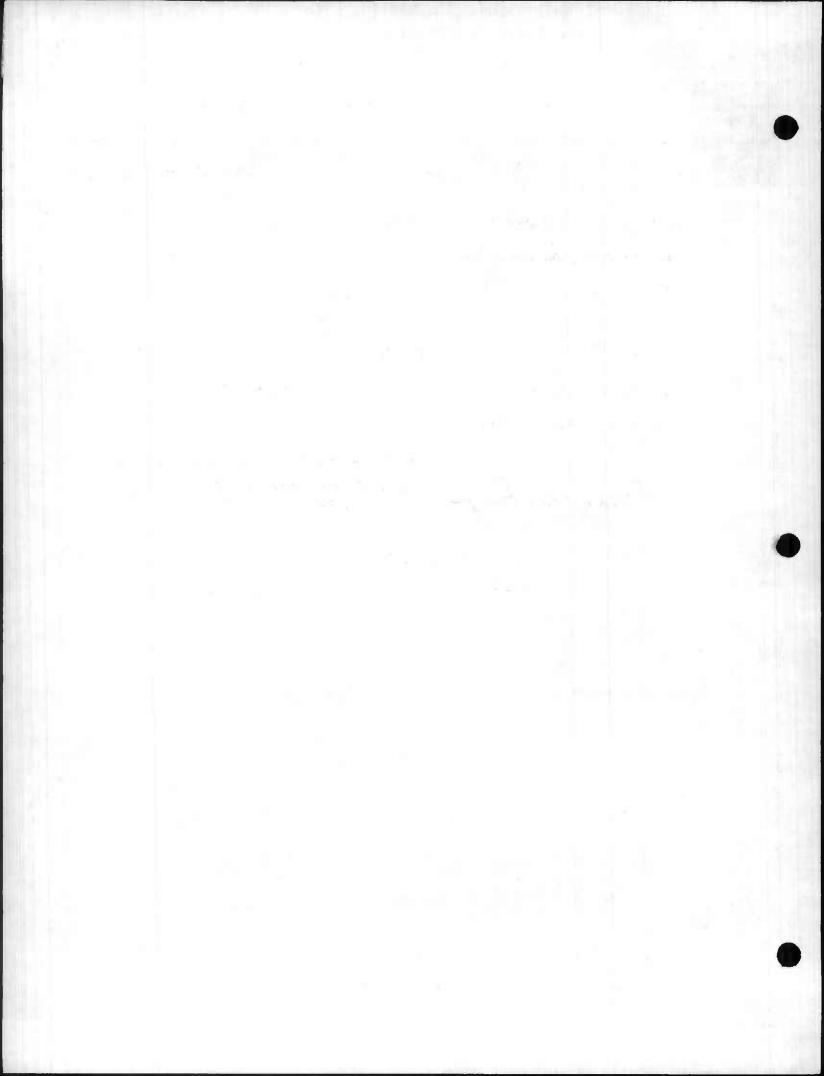
LEONARD SCOTT LOWERYItems: 23a pa	rt I,27,28a	-f per MEO				ertifica		Death	nemarri	Reg. No.	0 2	. 100		
Physician /Medical	1. Decedent's Nam	a (First, Middla, Las D SC	oti ott	LOWE	RY				2. Data of D Month Janua	Day 10	Yaar 98	3. Time of Death 500pm		
Examiner	4a Facility Nema (If not institution, give	a street and nun	nber)				4b. City, Town, or L	ocation of Dee					
	6136 TIL	SHMAN ISL						TILGHMAN						
Funeral Director	5. Sociel Security N 220-80-	1	MM 2DF	7. Aga (In yrs 33	: last birthda Yrs.	Months	Days		8. Data of Birth (Month, Day, Year) AUG. 24,1964 9. Birthplece (State or Foreit Country) MARYLAND					
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	11. Marital Status		12. Was Dece	dant Ever in t	U,S. 13			Hispanic Origin? (Sp pan, Maxican, Puerto	acify Yes or N	0- 14. Rac	e - America ck, Whita, a			
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yla Mend Mend To	CARROL	L STOLL	LOWER	Y			ARLINE LEONARD g Addrass (Streat and Number or Rural Route Number, City or Town, State, Zip Code)							
Aar 2 sh and lam		ame/Ralationship (Coda)		
P, N and feelth m 27	CARROLL S. LOWERY/FATHER P.O. BOX 134, TILGHMAN, MI											wn, Stata		
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Physician /Medical Examiner	Immadiata Causa (Final disaasa or condition rasulting in daath) NARCOTIC INTOXICATION Dua to (or as a consequence of):										1			
Je Je Je Je Je Je Je Je Je Je Je Je Je J	Due to (or as a consaquance or).													
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P.O. det the detechent ettecher	Part II. Other argin	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4				
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Division of To the Hospital or Attending Physician 24 hours effer death. To the Funeral birsctor: Affer this completely filled in by the funeral Medical Certification: 3	29a. Cartifiar (Check only one) Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place (Check only one) Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred and mariner stated.									a causa(s) and m	annar as sta	ated.		
To the within To the comple	29b. Signatura end	I titla of certifiar	911			29	o. C.	M.E.		29d. Data signi Januar	ad (Month, L 7 8 , 1	Day, Year) 1998		
	30. Nama and add	rass of person who	complated caus				reet	, Baltimo	re, Mai	yland 2	1201			
State	31. Data filed (Mor	oth, Day, Yaar)	32 B	enistrar's Sine	natura									
Registrar		JAN 09 19	98	Julia Da	widson-	Pandalle								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 8 0 2 7 6 7

					Ce	rtifica	ate of	Death		Reg. N	0.				
Dhuaisi		1. Decedent's Name (First, Middle, L	ast)			-			2. Date of De	ath		Vone	3. Tim	e of Death	
Physicia /Medic			Marcia			Lake	eman		Januar	y 22	! , 19	98"	6:13	2 AM	
Examin		4e. Fecility Name (If not institution, g						4b. City, Town, or	Location of Deet	h 4	c. County	of Death			
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Funeral Director		092-16-5176	Sex 1□M 2X F	7. Age (In yrs.	lest birthdey) 81 Yrs.	If Und Month	ler 1 Yea s Days			th ay, Year 0,	916	9. Birthpl Count NeW	lace (Ste try) YOYk	te or Foreig	
out the Wedes Examinet must be notified at		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						1/	Od Ineid	e City Llmits	
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- S		14508 Farmingto	n Creek	Road			0607			-			•		
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Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", eny injury or other traumatic event, the Medical Exa once.	Completed	(Specify only highest g		Ang E . \	(Give	kind of v DO NOT	vork done use retin	e during most of wo	orking 16b. KInd of Business/Industry						
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kad ic ev	To B	Curtis E. Lal	ceman					Kathar	ryn Bro	wn					
and Men marks umatic		19e. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addre	ss (Stree	at end Number or F			or Town,	Stete, Zip	Code)		
n 27 is ner trau		Marcia E. Nelso	on (f	riend)	Same	as	10								
of Health Item 27 i r other tra		20a. Method of Disposition		20b. F	Placa of Dispo	osition (N	ame of	2001	Date	20c. L	ocation -	City or Tov	wn, Stete)	
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Department of Important: If eny injury or once.			•	Cite				-			CSVI	110,	nut y	Taria	
Departrumporta eny inju		22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Betwee													
		23a. Part1. Enter the diseese, or cor shock, or heart failure. List only	nplications that ca	used the deat	h. Do not en	ter the m	ode of dy	ring, such es cardia	c or respiretory a	rrest,			Approxir	mate Between	
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efter deeth. Director: After th J in by the funeral	Certification:	3 Suicide 6 Could not determined)	28f. Location (City or To			er or Rural	Route N	lum <i>ber,</i>						
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5		Hocks	D20	367		Jai	nuary	/ 22,	199	8					
		30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type,	Print)									
		Joel/Kalman, M.	D., 61	11 Exec	utive	Blvd	. ,	Rockville	e, MD 2	0852	2				
Sta	te	31. Date filed (Month, Day, Year)	32. Re	mistrar's Signe	eture 70	1.00									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth **Physician** Month awson 5:23 p.m. 917,01 R 1998 JANUARY /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hopkins Johns BAHIMBIE CIT N/A 5. Social Security Number 7. Age (In yrs. lest birthday) If Undar 1 6. Sax Date of Birth (Month, Day, Year) 9. Birthpleca (State or Foreign **Funeral** Deys 1□ M 2XF 199-18-3350-A Director 77 MARCH27, 1920 VIRGINIA Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits man be nothed at 1 Yes 2 No Director PHILADELPHIA Philadelphia 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 129 N. 19139 51STREET USA Funeral items 2 12. Was Decedent Ever in U,S. Armad Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ☑ Year or Dates: Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. Pagas 1 end 2 should be filed within 72 hours after inent of Heelth end Mental Hygiena. 1 ☐ Never Married 2 ☐ Married 21215-0020 6 1 Yes 2 No Specify: by 3 Widowed 4 □ Divorced Specify: BLACK "natural", Completed the Medical 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) nd Mental Hygiena. markad other than Cotlege (1-4or 5+) PHILADELPHIA Etementery/Secondary (0-12) TEACHER AID PUBLIC SCHOOL 12TH Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Sumeme) Be WILLIE BURTON GRACIE MARABLE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) or other trace DIANE L. BLOUNT (DAUGHTER) 6716 13TH PLACE N.W. WASH, D.C. 20012 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from Stete permit. Page Department of Important: If any Injury or once. CATHEDRAL CEMETERY 1/24/98 PHIL, PA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Figureral Service Licenses AUSTIN ROYSTER FUNERAL HOME 14TH ST. N.W. WASH, DC. 20011 an complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximete Intervel Between Onsat and Daath **Physician** /Medical Immediate Ceuse (Finel 6-8 Weeks diseese or condition resulting in death) Examiner Due to (or as e consequence of) Saquentially list conditions, if eny, leading to immediata cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of) The law requires that the daath certificeta be exec Physician/Medical Due to (or as a consequanca of): esn Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? yd bengis 1 Yes 2 No 3 Probably 4 ☐ Unknown 2 8 24b. Were eutopsy findings aveilable prior to page 2 should Completed 24a. Wes en eutopsy complation of cause of deeth? 1 Yes 2 No certificeta 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes 2 No 1 Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth Date of Injury (Month, Dev Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident

P.O. Box 68760. Records, Division of Vital Hospital or Attanding Physician: the funeral To the Hospital or Attandl within 24 hours after death. To the Funeral Director: A

Medicai Certification: in by

3 Suicide 4 Homicide

29a. Certifier

6 Could not be

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Tertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end manner stated. 29b. Signature end title of certifier

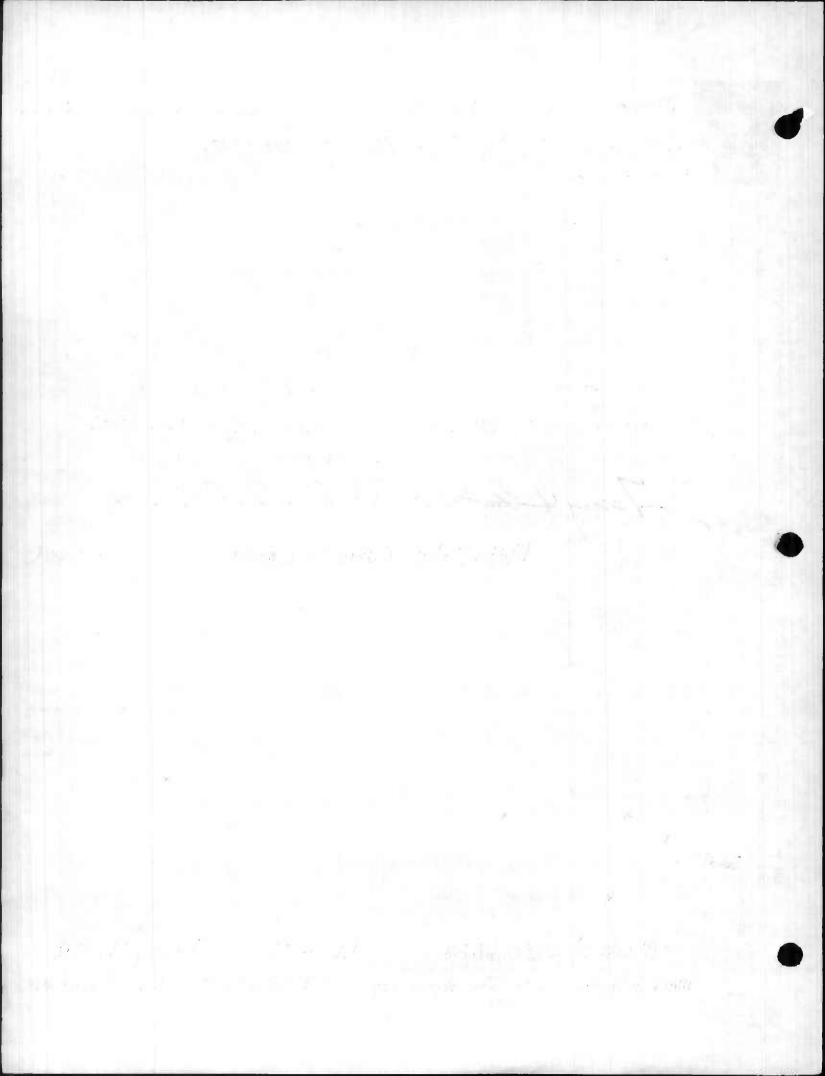
29c. License number

29d. Date signed (Month, Dey, Year)

completed ceuse of deeth (Item 23e) (Type, Print)

mo, PND, Johns Hookins Hospital, 600 N. Wolfe Street, Baltimore, Maryland 21287 Registrer's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No: 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ESSIL 4b. City, Town, or Location of Death 21 1998 LINION /Medical 4e. Fecility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** Washington Adventist Hospital /Care Links
ial Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year
Months Deys Takoma Park Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2QF 219-12-4825 Yrs. **Director** Oct. 8, 1921 76 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tra Medical Examinat name or notified at 10d. fnside City Limits 1 ☐ Yes 2 ☑ No Director ([ivi] Montgomery Takoma Park 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20912 1110 Jackson Avenue Funeral USA 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 72 hours eftar 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7. Hygiene. other than "na Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Depertment of Haalth and Mentel Hy Important: if item 27 is marked other any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Clark E. Roberts 2 Myrtle W. White 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (sister) 1110 Jackson Avenue, Takoma Park, MD Addessa S. Burnette 20912 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 St Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/24/98 Brentwood, MD Fort Lincoln Cemetery 22. Name end Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Oleven L Silver Spring, MD 20901 mou 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting In deeth) /Medical BRAN TUMOR
Due to (or as a consequence of): , 2 marks Examiner Examiner attending physician end for use as the burief-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) P.0. Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed peed page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No cartificate or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 Netural eftar death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) In by 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical etely (Check only one) To the the th To the within ;

29c. License number 29d. Date signed (Month, Day, 1) $D - 17874 \qquad 1 - 21 - 98$

COTTAGE CITY MD 20722

29d. Date signed (Month, Day, Yeer)

Registrar DHMH 16 Rev 6/95

1)

State

Red 26 - # 4a is NURsing Home within Hosp. per m.D.

31. Date filed (Month, Dey, Yeer) JAN 23

29b. Signature and title of cartifier

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)
S. M. NAYAR, M.D. 3717-38* M.E.

32. Registrar's Signature

whia Davidson-Randell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death **Physician** Ernst Drake Lundell Sr. January 15, 1998 /Medical 1:35 am 4a. Fecility Neme (If not institution, giva streat end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number If Under 1 Year 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Day, Yaar) 6. Sex Birthplaca (Steta or Foraign Country) **Funeral** Months Days 110 M 2□ F Yrs Director 579-18-1163 June 19, 1916 New York Usual Residence of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location th and Mantal Hygiene. 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Macical Examinar must be northed at 10d. Inside City Limits Director 1 ☐ Yas 2 ☑ No Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Coda 10g. Citizan of Whet Country? filed within 72 hours after death with 8211 Thoreau Drive Funeral 20817 United States 12. Was Dacedent Ever in U,S.
Armed Forcas?
1 ☑ Yes 2 ☐ No
If Yas, Give
Year or Datas: WWII 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Bleck, White, atc. 1 Never Marriad 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Spacify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Dacedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) U.S. Government Comptroller 17. Fethar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumema) Be Pegas 1 and 2 should be 1 ent of Haalth and Mantal 2 Gustav Ernst Fredrik Lundell Marguerite Drake 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Steta, Zip Code) or other train Ann C. Lundell/ Wife 8211 Thoreau Drive Bethesda, Maryland 20817 20b. Place of Disposition (Nema of cematary, cramatory or other place) January 16, 1998 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 X Cramation 3 ☐ Ramoval from Stata permit. Pega Department of Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) Montgomery Crematorium Inc. Bethesda, Maryland Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00335 Bethesda, Maryland 20814-3501 21. Signetura of Funaral Service Licensea M00335 Bethesda, Maryland 20814-350

23a. Partl. Enter the a sease, or can plications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory errast, shock, or heart lailura. Line only one cause on each line. **Physician** /Medical Immadiata Ceusa (Final diseasa or condition rasulting in death) Abdominal Aortic Aneurysm Rupture 3 Hours Examine Due to (or as a consaquance of): Atherosclerosis or Attending Physician: The law requires that the death carlificete be executed Sequantially list conditions, if any, laading to Immadiata ceuse. Entar Underlying Cause (Diseesa or Injury that initiated events resulting in daath) Last and burial-tren Dua to (or as a consequence of) P.O. Box 68760, physician Physician/Medical tha Dua to (or as a consequence of) USB BSU been signed by tha a should be deteched f Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Cardiomyopathy Completed by 24b. Wara autopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy parformed? Congestive Heart Failure paga 2 1 ☐ Yas 2 🖾 No cartificata 1 □ Yas 2 □ No funaral director, 25. Was cesa rafarred to medical axaminer? Be 26. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 ☑ Inpatiant 2 ☐ ER/Outpetiant 3 ☐ DOA Certification: To Aftar this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Naturai 5 Panding s efter daath. 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant in by tha 3 Suicide 6 Could not be detarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicida To the Hospital within 24 hours e To the Funeral C 1 Cartifying Phyalclan: To tha best of my knowledga, death occurred at tha tima, data and place, and due to tha ceusa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated. 29a, Cartifier Medical 29b. Signature end titla of certifiar 29c. Licansa number 29d. Data signed (Month, Dey, Year)

Records, Division of Vital

> State Registrar

20 1998

31. Data filad (Month, Day, Yaar)

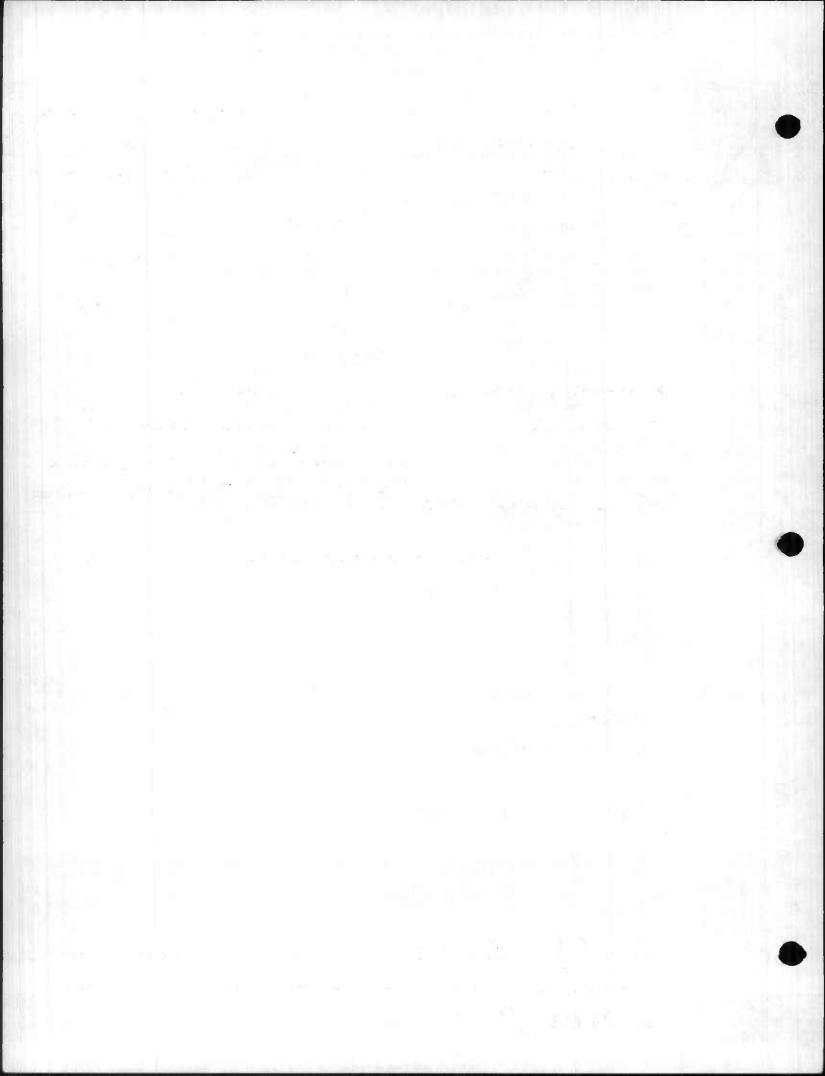
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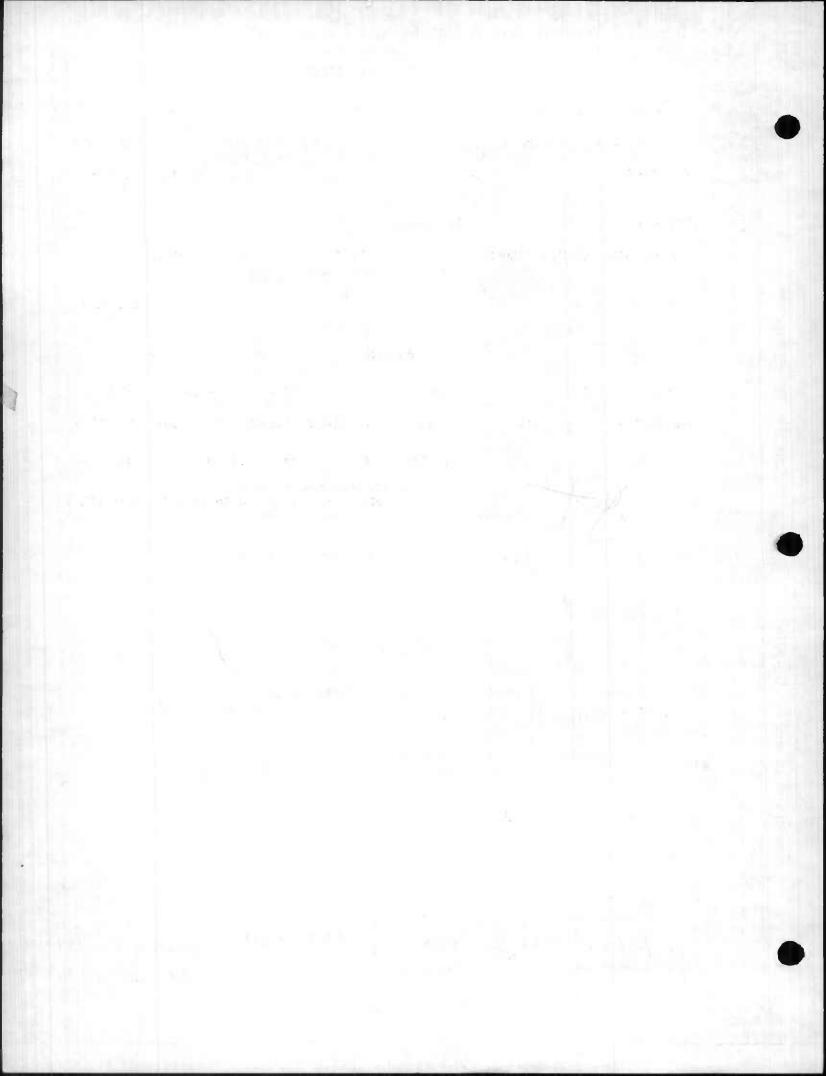
Daniel Rosenblum M.D. 10400 Connecticut Avenue #606 Kensington, Maryland 20895

January 15, 1998



State of Maryland / Department of Health and Mental Hygiene 98 0277

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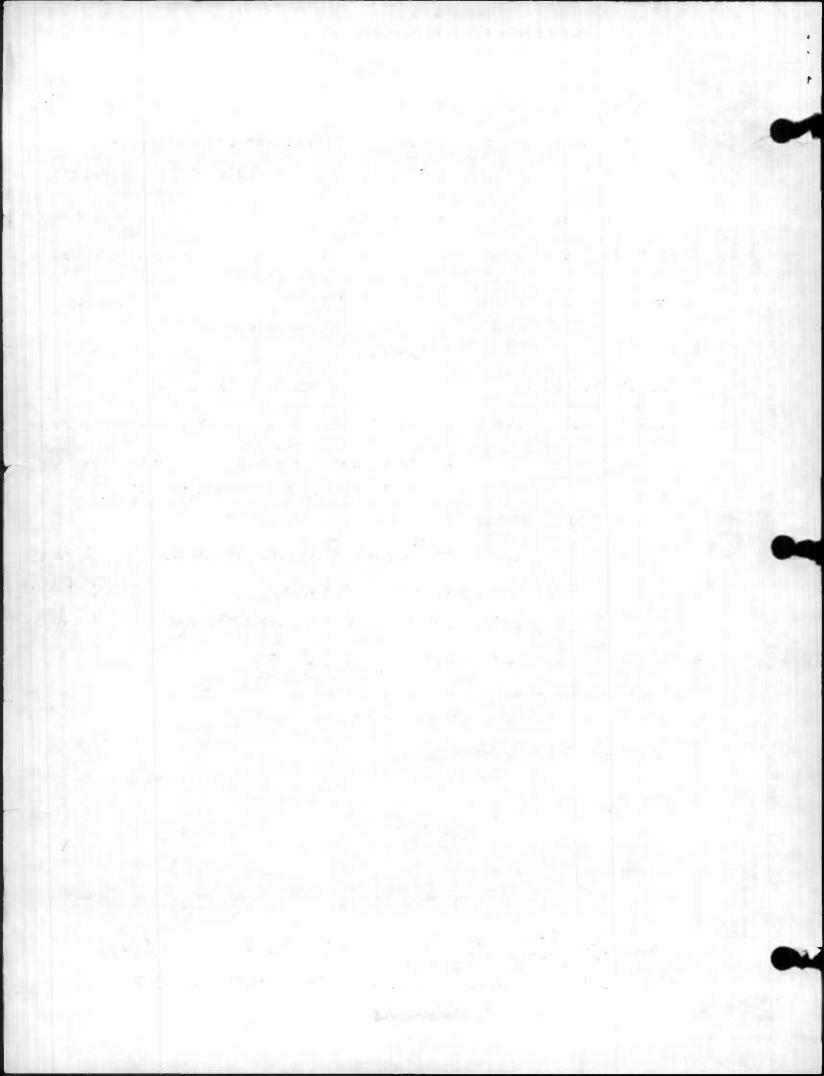


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Daath 1. Decedant's Nama (First, Middla, Last) Month Yaar **Physician** Little 1538 TradIA Henry 98 Jan /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6 Sax 9. Birthplaca (Stata or Foraign **Funeral** Days 15 M 2□ F 83 Yrs. 1915 Maryland 213-01-9251 Director Jan. Usual Rasidanca of Dacedant the Maryland 10c. City, Town or Location 10d Inside City Limits 10a Stata 10b. County 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Medical Examinar must be notified at 1 ☐ Yas 2 No Carrol1 New Windsor Directo 10e. Street and Number 10f. Zip Coda 10g, Citizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours effer death with it Department of Health and Mentel Hygiene. Important: If flem 27 is marked other than 'natural' any injury or other traumatic event 2134 Old New Windsor Pike 21776 United States Funeral 12. Was Dacadant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 M No If Yas, Give Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, etc. 1 Navar Marriad 2 Marriad 1 ☐ Yas 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorcad white Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade complated) Collaga (1-4or 5+) Elementery/Secondary (0-12) 11 Machinist Mack Truck 17, Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Carroll K. Little Maude Schaeffer 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21776 19a. Informant's Name/Relationship (Typa, Print) 2134 Old New Windsor Pike, New Windsor, MD Barbara Garity, daughter 20b. Place of Disposition (Nama of cematery, cramatory or other place) 1/17/98 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Krider's Church Cemetery Westminster, MD 21. Signatura of Funaral Sarvica Licansaa 22. Nama and Addrass of Facility Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, Kathure Pritts - Sweiter 412 Washington Rd., Wes 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. MD Approximete Intarval Batwaan Onsat and Death **Physician** Failure, Acute Liver + ReNAl /Medical Immediate Causa (Final disease or condition rasulting in daath) Examiner Examine 20 Volemic physician and s the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last that the death certificate be execu Division of Vital Records, P.O. Box 68760, Physician/Medicai as Eparin KX Intravenous USB tor ATTICAL signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? Obstructive Rulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known Visease þ 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed Fibrillation certificate has b 2 0 No 1 ☐ Yas 1 ☐ Yes 2 ☐ No Attending Physician: director. Be 25. Was case referred to medical axaminar? 26. Placa of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 Dimpatient 2 ER/Outpatient 3 DOA Certification: To After this 28e. Deta of Injury (Month, Day Year) 27. Menner of Deeth funeral 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? fniun 5 Pending deeth. invastigation 1 Yes 2 No 2 Accidant after deeth Director: 6 Could not be datarminad 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) in 24 hou... 4 T Homicida 50 Hospital 1D Certifying Phyelclen: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the ceuse(s) and menner as stated. 29a. Certifies edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. within 2.
To the F 29b. 29c. License number 29d. Data signed (Month, Day, Year) 1)09557 addrass of person who completed cause of death (Itam 23a) (Type, Print) John E. Steers, M.D. Stoner Westminster, My 2111 32. Degistrar's Signature 31. Deta filed (Month, Day, Year)

State Registrar

JAN16



State of Maryland / Department of Health and Mental Hygiene

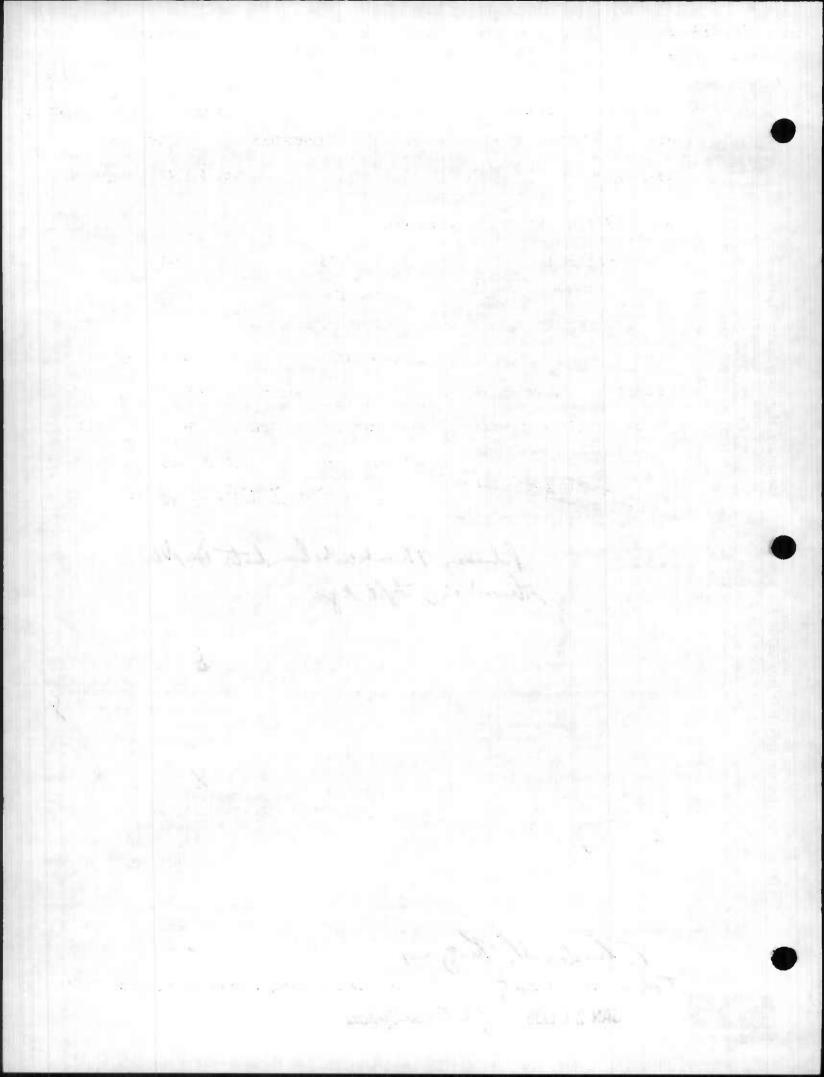
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Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev MORRILL Q R JANUARY 17, 1998 8:45AM 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL 8. Dele of Birth (Month, Dey, Year) Feb. 24, 1925 Phila. If Under 1 Yeer If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1 M 2 □ F 208-16-7930 72 Yrs Penna Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City I Imits 1 ☐ Yes 2√ No Maryland Talbot Bozman 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 21612 U.S.A. 23875 Ebb Pt. Rd. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Nayes 2 D No Nayy If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Marketing IBM 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William Jackson Merrill Dorothy Ruggles 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Helen W. Merrill P.O. Box 337 Bozman, Maryland 21612 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlat 2X Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) Capitol Crematory Jan 19,1998 Dover, Delaware 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663 Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory shock, or heart feilure. List only one cause on each line. LeuKeMiA immediate Ceuse (Finel diseese or condition resulting in death) 3 MONHIS

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. Stete

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Funeral

Director

"natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours efter death 1 Department of Health end Mantel Hygiena. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumetic event, tra Madrial Examinal mass

Baltimore, Maryland 21215-0020

Director

Funeral

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or Attanding Physician: The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760.

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Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest	b. MYEIC c. Sepe	(or es e consequence of	Stic Sy,	ndrum 2	3 months 2 veets
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3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At to building, etc. (Special Control of the Control of th	nome, farm, street, factorify)	ory, office	28f. Location (Street and Numb City or Town, State)	per or Rural Route Number,
29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my kn ilner: On the basis of exemin- end manner stated.	owledge, deeth occurre etion end/or investigation	ed et the time, dete end plecon, in my opinion, deeth occ	ce, end due to the ceuse(s) end me curred et the time, date end plece,	enner es stated. end due to the cause(s)
29b. Signeture end title of certifier	Jayoh.	2	DSA 90	29d. Date signe	d (Month, Day, Year)
30. Name and address of person who do	completed cause of deeth (Ite	-120 t	Baltimor	le Maryland	L 21287

State Registrar

600 31. Dete filed (Month, Day, Year) JAN 2 0 1998

Streat 32. Registrer's Signature

Julia Davidson



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Deta of Death Month **Physician** GEORGE **EDWARD** MARKELL 8,1998 JAN. 4:45 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 32528 COVEY'S LANDING ROAD CORDOVA TALBOT If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)
AUG. 13, 1915

8. Birthpleca (Stete or Country)
MARYLAND 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthpleca (Stete or Foreign **Funeral** Deys Months Hours 218-14-8944 Vrs 82 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, It a Maxical Expansion must be notified at 1 ☐ Yes 2 ☐ No Director MD TALBOT CORDOVA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 32528 COVEY'S LANDING ROAD 21625 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Manfal Hygiena. Important: if item 27 is merked other than "natural", or itams 28a any injury or other traumatic avant Funerai 12. Was Decedent Ever in U,S Armed Forcas? 14. Race - Americen Indien, Black, White, etc. Wes Decadent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Ricen, etc.) 11. Maritel Status 1 Never Married 2F Married Yes 20 No f Yes, Give XX Yeer or Detes: WHITE 1 Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadant's Education (Spacify only highest grede complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 5+ FARMER AGRICULTURE 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be GEORGE E. MARKELL ETHEL VIRGINIA PERRY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ELIZABETH A. MARKELL/WIFE 32528 COVEY'S LANDING ROAD, CORDOVA, MD 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete FAIRVIEW CHURCH CEM. 1 Burial 2 Cremetion 3 Removel from Stata 1-13 CORDOVA. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME Newyane 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Intervel Between Onsat and Death **Physician** cordent with arebeller of us /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underfying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es a consaquenca of): Physician/Medical Due to (or es a consequence of) attanding ed by the at detached for Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco use-contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown signed l by 24b. Ware autopsy findings eveileble prior to completion of causa of deeth? 24a. Was an autopsy performed? peen : Completed Proctured aw page 2 has 2 1 No 1 Tyes 1 ☐ Yas 2 ☐ No certificate To the Hospital or Attanding Physician: within 24 hours aftar death.

To the Funeral Director: After this certific. Be 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Certification: To 1 Yes 2 No Other: 4□ Nursing Homa 5 ☐ Residence 6 □ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funaral 27. Manner of Deeth 28a. Dete of Injury (Month, Dev Yeer) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Awatural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowladge, daeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. Medicai 29a Certifier 29c. License number 29d. Date sigged (Month, Day, Year) 29b. Signeture end the d 198 cause of deeth (Item 23e) (Type, Pri

Registrar

State

31. Date filed (Month, Day, Year)

JAN 12

32. Registrer's Signature

Lulia Davidson

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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AND STATES

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** Frederick A. Mockabee, Jr. January 15, 1998 8:55 PM /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel General Hospital Annapolis Anne Arundel If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1⊠M 2□ F 579-42-8505 Vrs 63 Director March 16, 1934 Oklahoma Usual Rasidanca of Dacedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1⊠ Yas 2□ No Director Maryland | Anne Arundel Edgewater 10e. Street and Numbar 10f. Zip Coda 10g, Citizen of What Country? ö 1506 Bishop Road 23a 21037 United States Funeral **Items** 12. Was Decedent Evar in U,S. Armad Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status 14. Race - American Indian, Black. Whita, atc. 72 hours after 1 XYas 2 No If Yas, Giva Yaar or Datas: Korea 1 ☐ Naver Married 2 ☑ Married Baltimore, Maryland 21215-0020 natural, or 1 Tyas 2 No Specify Specify py 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondary (0-12) Collega (1-4or 5+) Maintenance Engineer Apartment Complex th end Mentel Hygie 7 Is marked other t permit. Pages 1 and 2 should be filed.
Department of Health and Mentel Hvmir important: if item 27 is master any injury or other. 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Frederick A. Mockabee, Sr. Pearl Elizabeth Hale 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Barbara L. Mockabee/Wife 1506 Bishop Road, Edgewater, Maryland 21037 20b. Plece of Disposition (Nama of cematary, crematory or other place) an. 19, 1998 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland Parklawn Memorial Park 21. Signatura of Funeral Sarvica Licensaa

22. Nama and Address of Facility
Robert A. Pumphrey Funeral Home/
Possible A. Pumphrey Funeral Home/
Possible A. Pumphrey Funeral Home/
Chase, Inc.

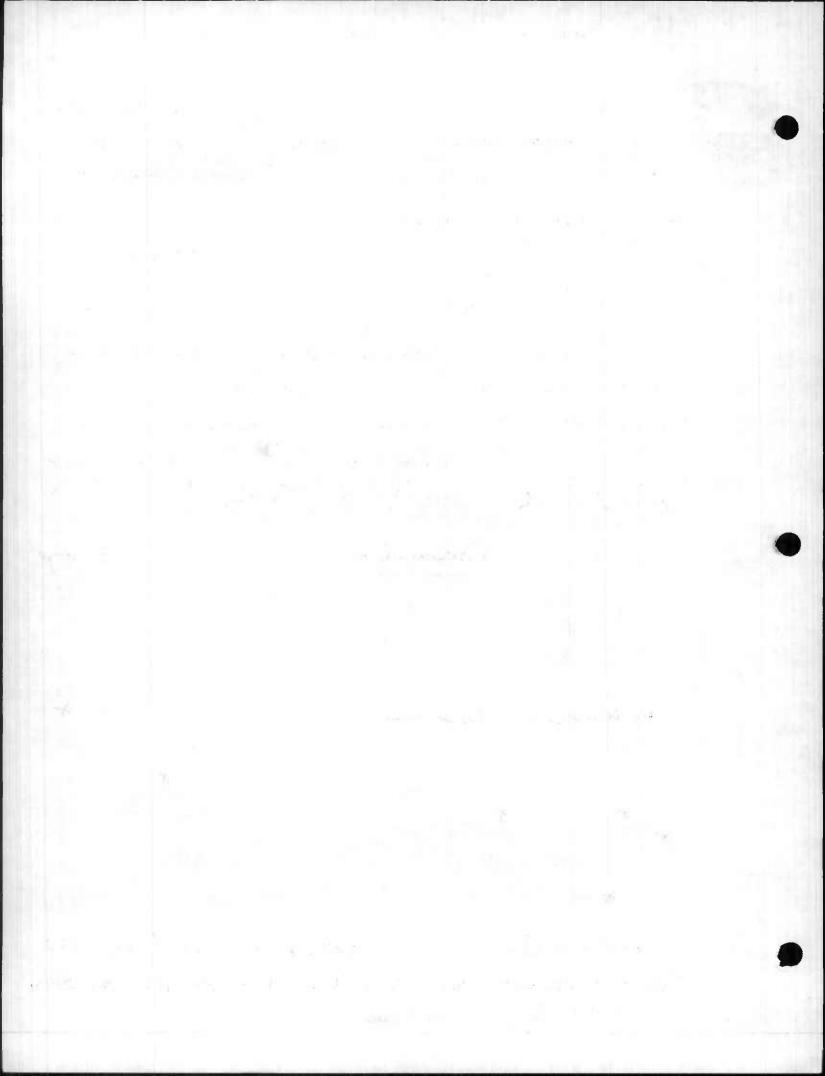
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest,

Approximate Approximate Interval Batwaan Onsat and Death **Physician** /Medicai Immediata Cause (Final disaasa or condition rasulting In death) Merman, -Examiner Due to (or as a consaquence of): Examiner the death certificate be axecuted Sequantially list conditions, if eny, leading to immadiata cause. Entar Undarlying Causa (Disaase or Injury that initiated evants rasulting in death) Last pue Dua to (or as e consequança of): physician er s the buriel-to Box 68760. Physician/Medical Due to (or es e consequence of): 35 attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. ed by the a P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown signed b Records, þ been sir 24b. Wara autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy has paga 2 1 ☐ Yas 2 No cartificate 1 ☐ Yas 2 ☐ No Division of Vital al or Attending Physician: The safter death.
Il Diractor: After this cartificated in by the funeral diractor, pa 25. Was casa rafarred to medical exeminar?

1 Yas 2 No Be 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Daath 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No investigation 2 Accidant 6 Could not be dataminad 3 ☐ Suicida 28a. Pleca of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homlcide 24 hours Hospital Cartifying Physicien: To tha best of my knowledge, daath occurred at tha tima, date and piece, and due to tha ceuse(s) end mennar as stetad.

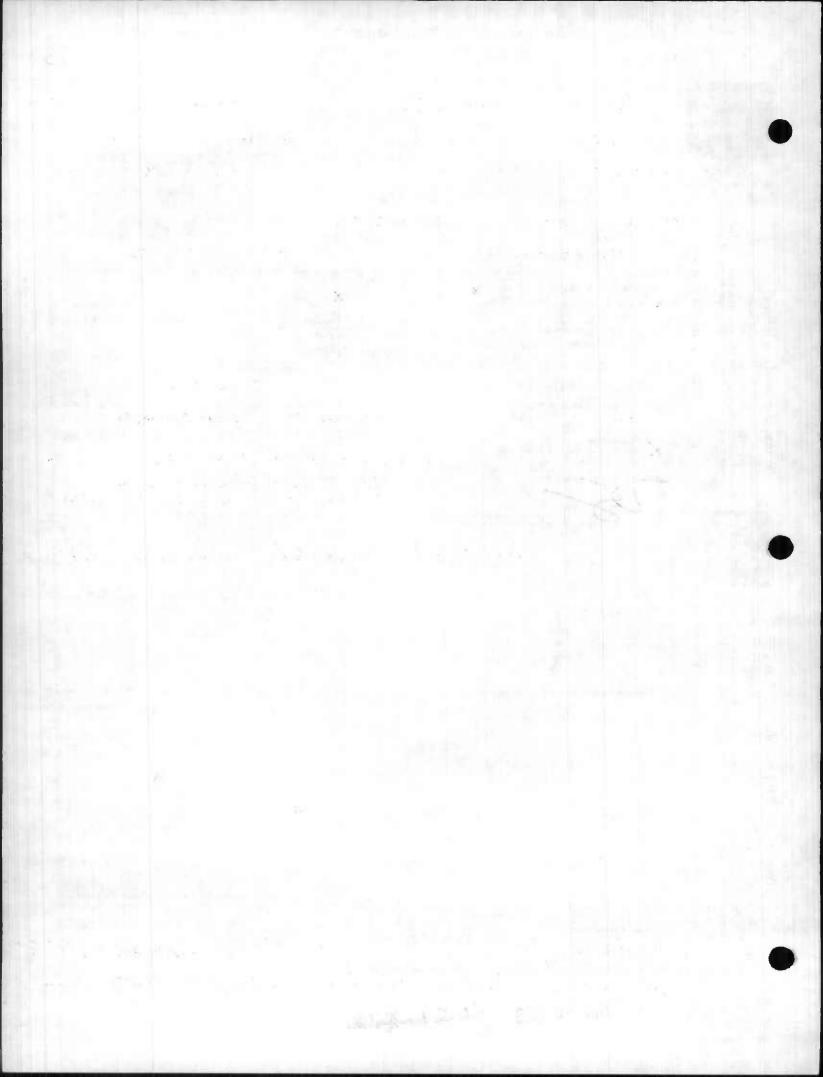
2 Medical Examiner: On tha bests of axamination end/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the ceuse(s) and menner statad. To the Hospi within 24 hou To the Funer completely fil icai 29a. Certifiar (Check only one) 29b. Signatura and title of cartifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) 10+ 145 30. Nama and addrass of person who complated causa of death (item 23e) (Type, Print) Medical Ray Annapolis MO 21401 LER MO 2003 32. Registrar's Signatura State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q 0777

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State	30. Nama and addrass of person who of the person		MONTRO	SE RI	Rockvi	lle ru	2885	2



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Hygiena. other than "naturem, pre Medical		Elementery/Secondary (0-12)	College (1-4or 5+)		<i>Bo Not</i> us Secre		during most of ward)	OIKING	NSA		
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1/		Ame a	Rosa	i no	P		D	24573		JMUM	4 21	, 1998
		30. Name and address of person who	o completed ceus	se of deeth (Item	m 23e) (Type,	Print)	Jan	W BLVI), SILVE	Lipsing	m	0 2050
State	3	31. Data filed (Month, Day, Year)	32. R	legistrar's Sign	ature							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 15, 1998 **Physician** George Anthony Miller, Jr. January 3:30 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1975 LaPointe Drive Wheaton Montgomery Hours Min. 8. Date of Birth (Month, Dey, April 25, 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2□ F Months Days 141-70-7830 Yrs. 1964 Director 33 Pennsylvania Usual Residence of Decedent the Maryland e or 28a-f show 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be LaPointe 20902 Drive 1975 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 10 Wes 2 □ No 1983 − 17 Ves, Give Year or Dates: 1997 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. d 2 should be filed within 72 hours after of the and Mental Hygienes.
7 is marked other than "natural", or fler traumatic event, the Medical Exercites. 1 Never Married 2 Married 21215-0020 1□ Yes 2√ No Completed by Specify 3 ☐ Widowed 4 ☐ Divorced **Black** 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Food Service Supervisor U. S. Army Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be file ment of Health and Mental Higant: If Item 27 is marked oth lury or other traumatic even Be George A. Miller, Sr. Dancy Patricia 19a. Informant's Name/Reletionship (Type, Print) (wife) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Carol Yvette Collins-Miller Same as 10 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-26-98 Arlington, Virginia Arlington National Cem. 21. Signeture of Funeral Service Licensee Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical 17 months a Metastatic Non-Small Cell Cancer of the Lung Examiner Due to (or as a consequence of): Examiner Non-Small Cell Lung Cancer sician and burial-transit that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): physician a Box 68760. Physician/Medical Due to (or es a consequence of) 88 Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed l Records, þ 24b. Were autopsy findings avelleble prior to completion of cause of deeth? 24e. Wes an autopsy performed? Completed page 2 1 Yes 2 No certificate 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifica stell filled in by the funeral director, it 25. Was cese referred to medical examiner?

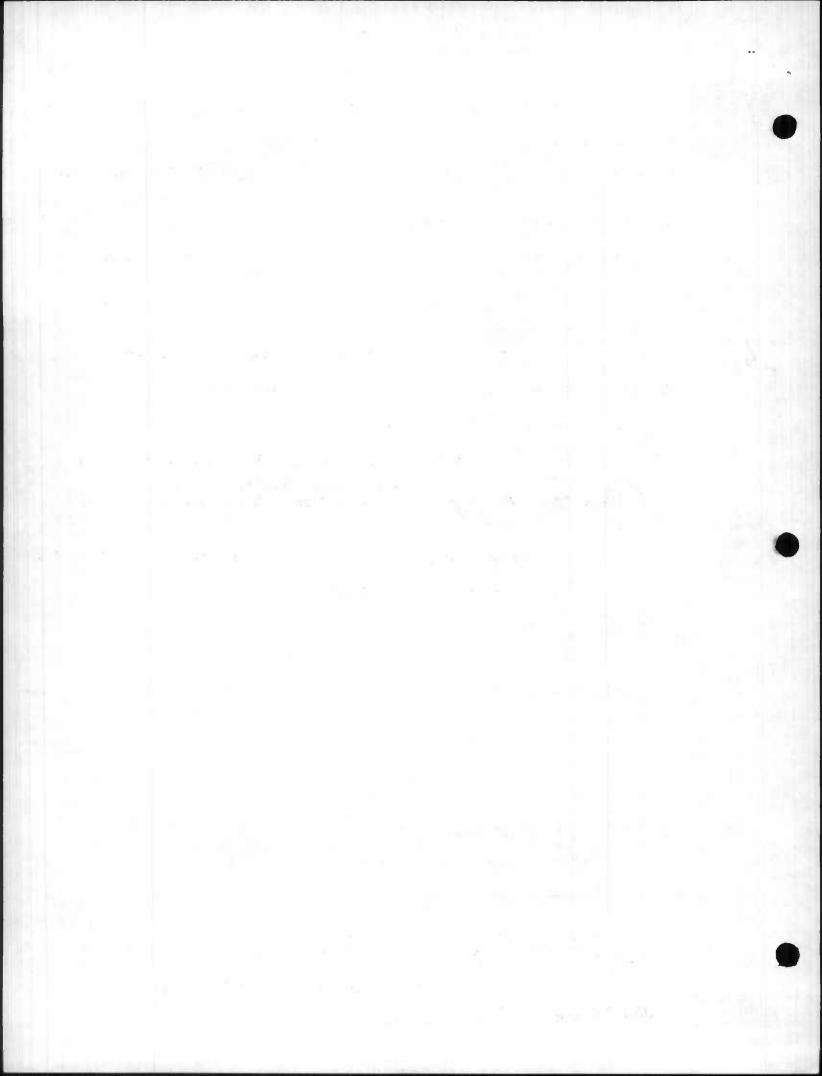
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel
2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 🛣 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated 29a. Certifier Medicai (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number Army Officer 29b. Signeture end title of certiful 29d. Date signed (Month, Dey, Year) Col/MC 579721813 January 18, 1998 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Alfred B. Brooks, M. D., 6900 Georgia Avenue, NW, Washington, DC 20307 JAN 20 1998 32. Registrar's Signature State

who Devidson Randelle

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Registrar

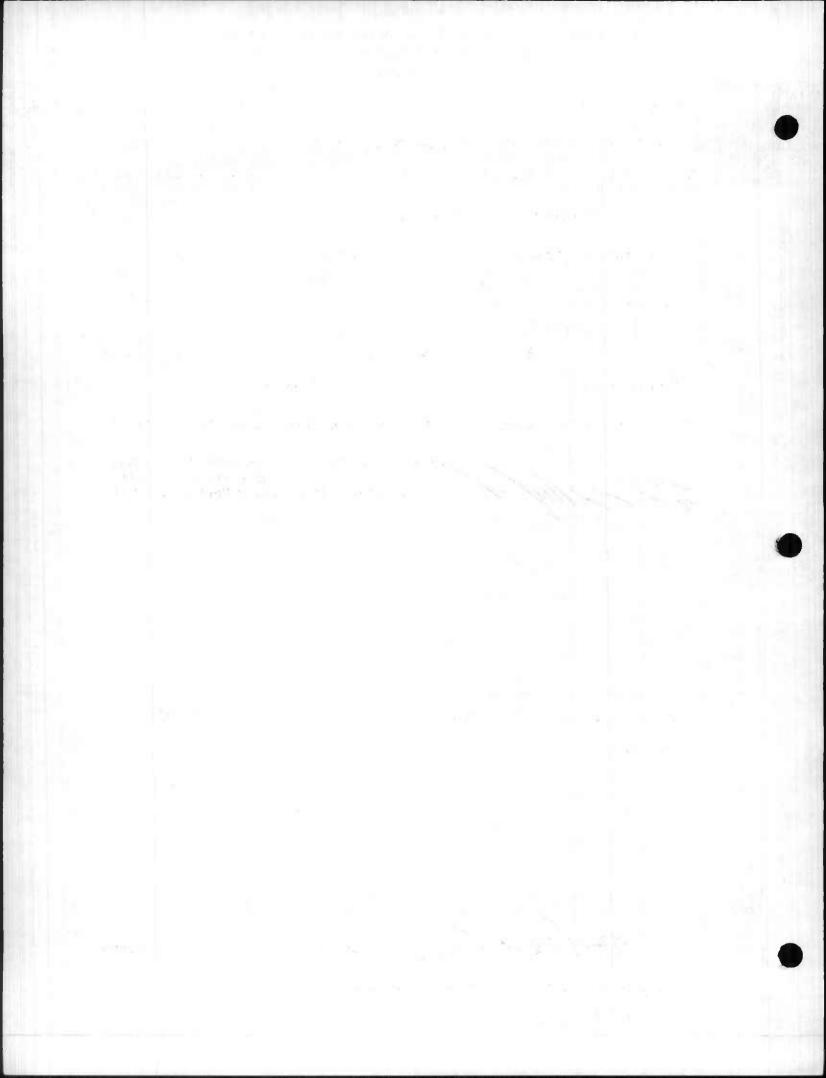
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State of Maryland / Department of Health and Mental Hygiene 98 02782

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uneral rector	5. Social Security Numb 577-18-2930 Usual Residence of Dec	er 6. S	ex □M 2□F	Age (In yrs. 77	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hr. Hours Min	8. Date (Mon July	of Birth th, Day, Y	920	9. Birthplac Country, Washi	e (State or Foreign ngton, Do
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	30. Name and address of	t person who	completed cause of	of death (iten	1 23a) (Type, F	Print)							

DHMH 16 Rev 6/95



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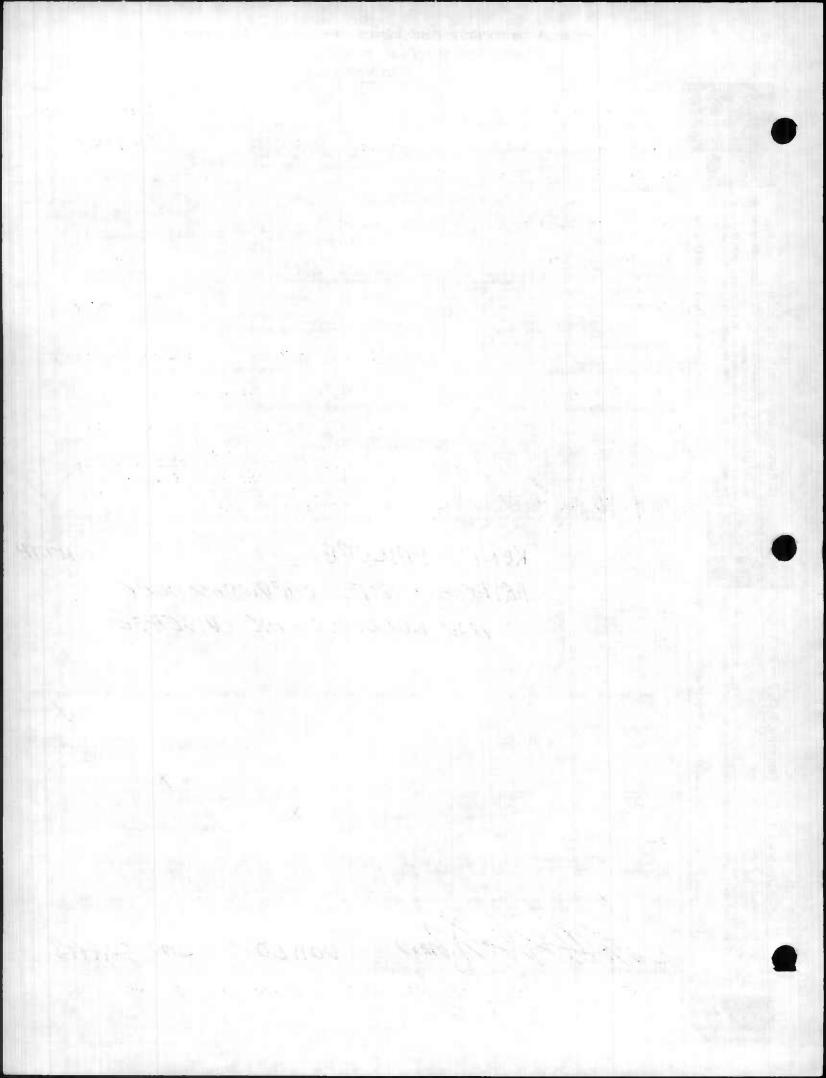
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2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

30. Neme and eddress of person who completed cause of Beath (Item 23e) (Type, Print)

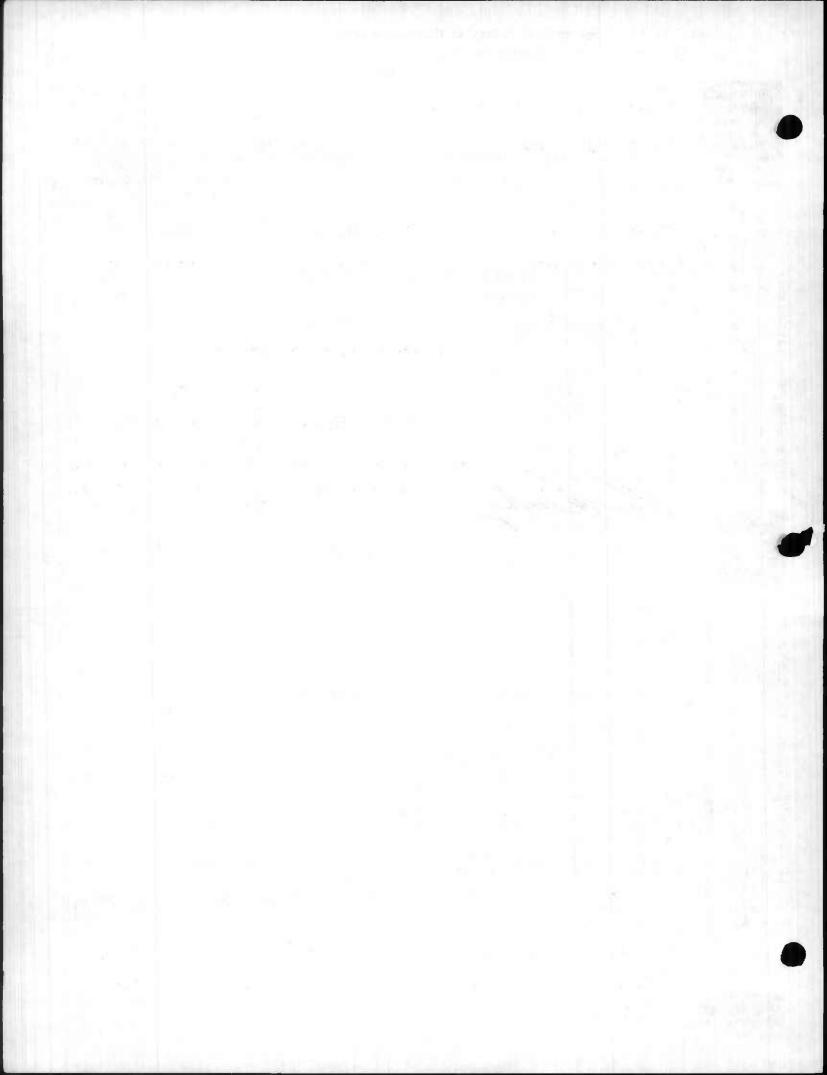
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State Registrar 29b. Signeture end titlig



State of Maryland / Department of Health and Mental Hygiene 98 02784

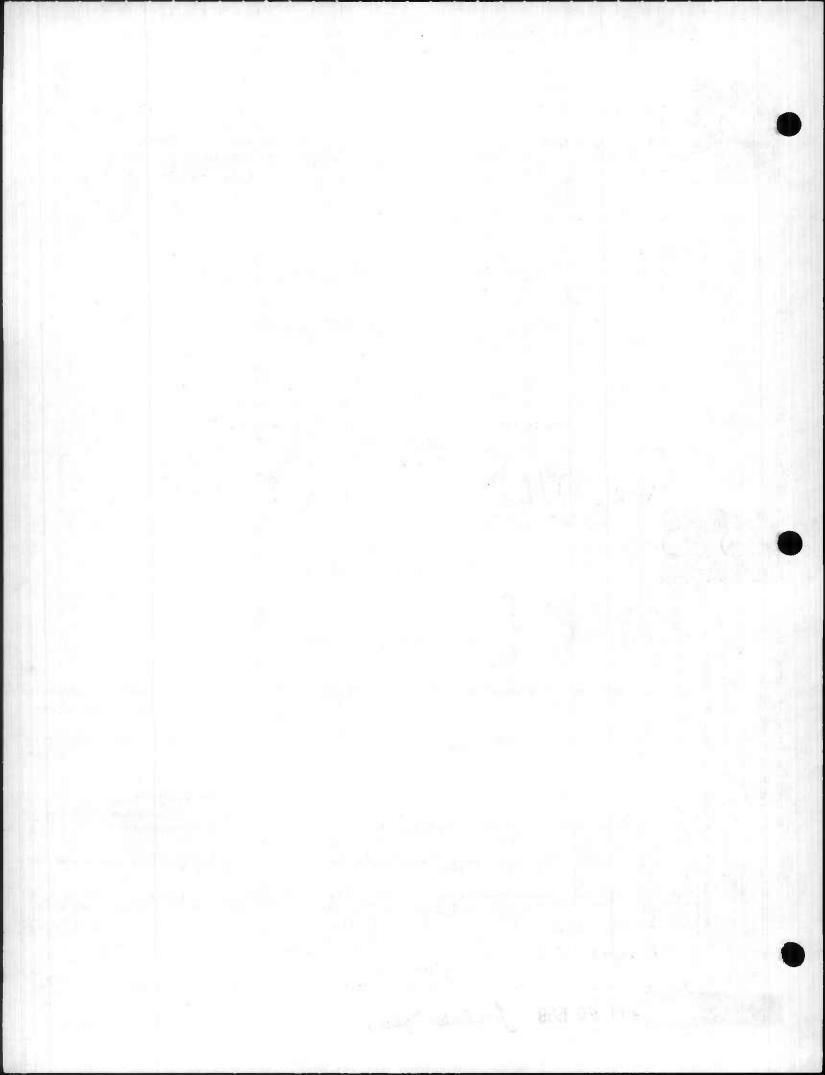
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State of Maryland / Department of Health and Mental Hygiene

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9a. Informent's Na <i>me/</i> Relation					18. Mother's Na	me (First, Middle	, Maiden Sumem	ne)	
Ward Douglas					Mary I	Louise Me	eng		
	onship (Type, Print)		19b. Meiling	Address (Stree	t end Number or F	lurei Route Numb	er, City or Town,	Stete, Zip Code)	
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0e. Method of Disposition	an O Domestida	20b.	Plece of Disposi cemetery, creme	ition (Neme of etory or other pla	January	Deta 17 1000	20c. Location -	City or Town, St	ate
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17/15/) luling	M006	89		Rockvill	e, Mary	land 208		
23a. Part 1. Anter the disease stocky or heart failure) L	or complications the list only one cause of	at caused the dee on each line.	th. Do not anter	r the moda of dy	lng, such es cardia	c or respiratory e	rrast,	Interv	ximata al Between
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ert II. Other significent cond	litions contributing to	daath but not res	sulting In the und	derlying cause gi	ven in Pert I.	23b. Did	tobacco uee cor	ntribute to the ca	usa of death?
Left Hydronep	hrosis					10	Yes 28 No	3 Probably	4 Unknown
Left Pyonephr	itis					24a. Was	en eutopsy	24b. Were euto availeble	prior to
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5. Wes cese referred to med	Hospitel:	☐ Inpatient 2 ☐	FR/Outnetient	3□ DOA Ott	la mare	dome 5 🖾 Resid		er (Specify)	
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	1 Neturel 5 Pen 2 Accident Inve 3 Suicide 6 Cou		4 Homicide determined building, etc. (Spacif	4 Homicide determined building, etc. (Spacify)	3 Suicide determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Spacify)	4 Homloide determined building, etc. (Spacify)	4 Homlcide building, etc. (Specify)		

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Day 09:30 AM MCKINNE) MARY MARGARET JANUARY 17,1998 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 9000 ORBIT LANE LANHAM PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of 8irth (Month, Day, 5. Social Security Number 9. Birthplece (Steta or Foreign Country) West Virginia 7. Age (In yrs. lest birthday) **Funeral** 1□ M 2√ F Deys Yrs. Director 87 1910 West 235-12-2864 Usual Rasidance of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be nothed at 1 ☐ Yes 2 ☑ No Director MD Prince George's Lanham 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9000 Orbit Lane Funeral 20706 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Completed by Specify White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry lith and Mentel Hygiene. 27 is marked other than "r r traumatic event, the Nex Elamantary/Secondery (0-12) College (1-4or 5+) 8 Factory Worker Glass Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Peges 1 end 2 should be file iment of Heelth end Mentel Hent: If item 27 is marked oth lury or other traumatic even Be Wendell Gombarcik Elizabeth Karlak 19e. Informent's Neme/Reletionship (Type, Print) (daughter)9b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9000 Orbit Lane, Lanham, MD Susanne Pollock Barnes 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramovel from Stete permit. Pege Department of Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 1/20/98 Silver Spring, MD 22. Name end Address of Fecility Francis J. Collins Funeral 21. Signeture-of Funeral Service Licensee 500 University Blvd. West Home, Inc. Coren Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximeta Intarvel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final · ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Dua to (or es e consequenca of) Examiner buniel-trensit Sequentially list conditions, if eny, leading to Immediate causa. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Physician/Medicai Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Wars autopsy findings eveileble prior to completion of cause of deeth? Be Completed 24e. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case rafarred to madical 26. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manper of Deeth 28e. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be datermined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, afc. (Specify) 4 Homlcide

The law requires that the death certificate be executed and P.O. Box 68760. ate hes been signed by the ettending p page 2 should be deteched for use es Records. this certificate Division of Vital or Attending Physician: After s efter deeth. filled in by

the Meryland

death with

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Location (Street end Number or Rural Route Number, City or Town, Stata)

1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date end place, end due to the causa(s) and manner as steted.

2 Madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) end men ar stated. (Check only one) 29b. Signature and title of certifier

29a. Certifiar

29c. License numbar DME

29d. Date signed (Month, Dey, Yeer) JANUARY 19, 1998

eath (Item 23e) (Type, Print)

JR . HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 MARIO MD 3001 JAN 21 1998 31. Date filed

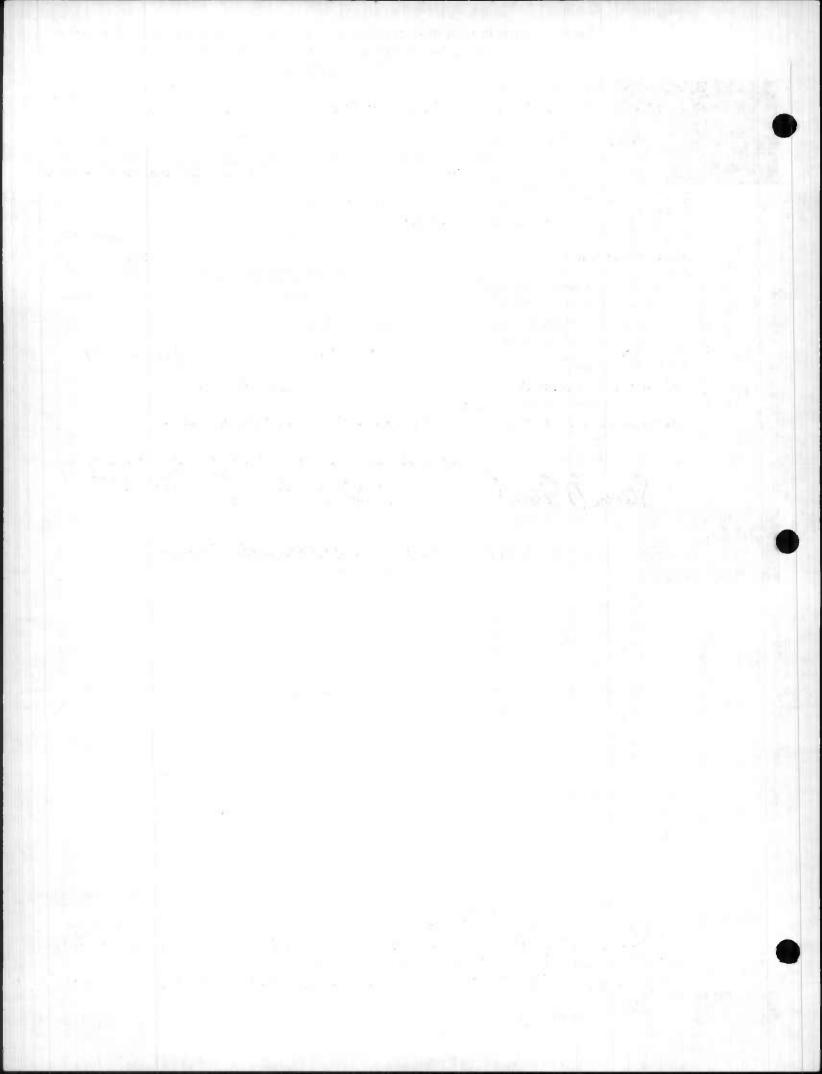
State Registrar

Medical

32. Registrar's Signature ul Davidson

24 hours Hospital

within 2 To the I



State of Maryland / Department of Health and Mental Hygiene

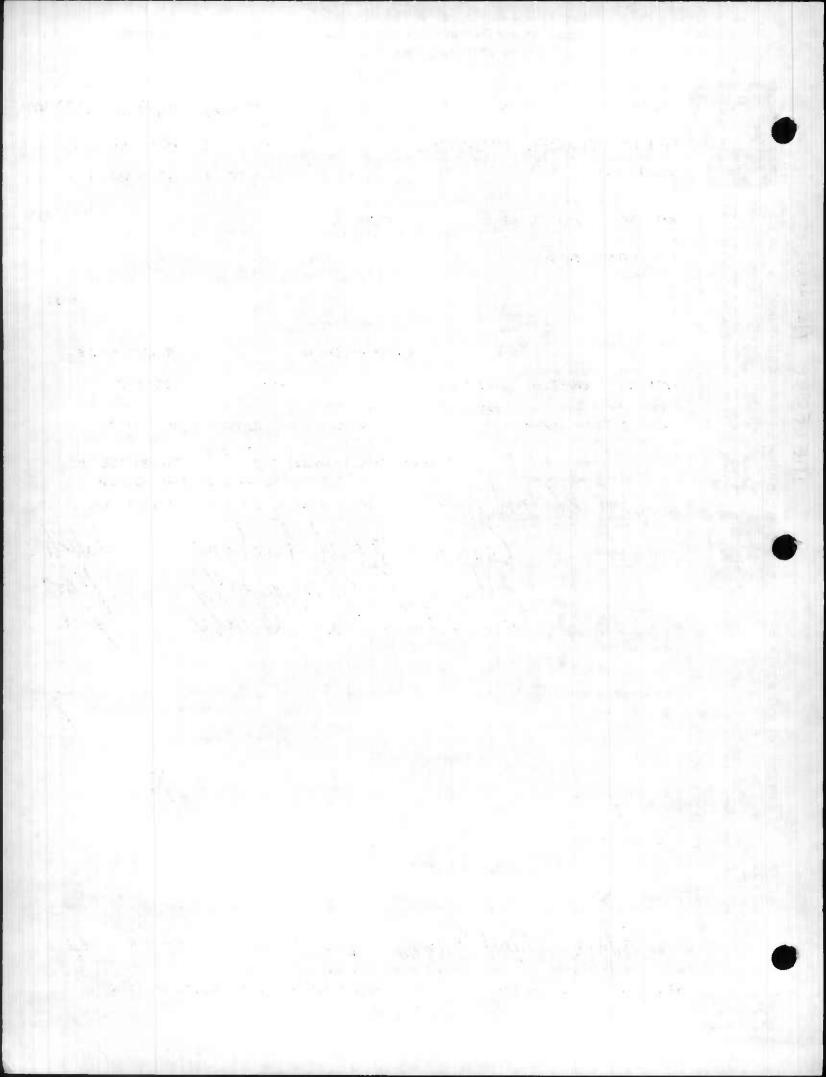
		Decedent's Neme (First, Mid	Idla Last)		Ce	rtificate o	f Death	2, Date of De	Reg. No.) ()	. Time of Deeth
Physic	ian	MILDRED F. Mc						Month	Day	Year	4:55 PM
_/Med		4e. Fecility Name (If not Institut		nhar)			4b. City, Town, or	Location of Death	4c. County	773	1.2211
Exami	ner			110017						comery	
		Holy Cross Hos 5. Social Security Number	•	7. Age (In yrs.	last hirthday	If Under 1 Yes	Silver Si			, ,	/Chata a - Faraira
Funeral Director	_	290-01-4236 Usual Residence of Decedent	1□M 2X)F	r. ngo (iii yis.	88 Yrs.	Months Day		. (Month, Da	9, 1909	Country) Ohio	e (Steta or Foraign
land		10a. State 10b. Coun	ty	10c. Ci	ity, Town or L	ocation				10d.	Inside City Limits
ith the Marylan or 28a-f show	Ö	Maryland Mont	gomery	6.5	lver S	nring					1 □ Yes 2 🗓 📉
28a	Directo	10e. Street and Number	gomery	01	TAGE	10f. Zip Code	9		10g. Citizen of \	What Country?	,
1th with 23a or unt be		101 C14-1- D				20904			United S		
ne 2;	era	101 Carlisle D	12. Was Dece	dent Ever in L	IS 13		f Hispanic Orlgin? (9			e - American I	Indian
21215-0020 d within 72 hours after death with the Maryland giene. If then "natural", or ferms 23s or 28s-f show then "natural" and the notified at	by Funeral	1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed For	rces? 2X No e	7,0.	If Yes, specify Co	f Hispanlc Orlgin? (Suban, Mexican, Puer Specify:	to Rican, etc.)	Specify	ck, White, etc.	
15-002 72 hours natural,	Completed by	15. Deced	ent's Education		16e. Dece	dent's Usual Occ	cupation		16b. Kind of Bu		
T 5 1 2	ple	(Specify only nigr Elementery/Secondary (0-12	past grada complated) College (1	-4or 5+)	lifa.	DO NOT usa reti	ne during most of wo ired)	rking			
d 212 filed within Hygiene. ther then	Ou	12	0	40.01)	Home	maker			Home		
/land Sulphan All Hall Hyginked other ritic event, in	Be	17. Fether's Name (First, Middle	a, Last)				18. Mother's Na	me (First, Middla,	Maidan Suman	na)	
ylan ould be Mental erked o	To	Walter Slane					Effie :	Page			
Maryland d 2 should be flie th end Mental Hy 7 is merked othe		19a. Informant's Name/Relation	nship (Typa, Print)		19b. Maili	ing Address (Stre	et and Number or R	ural Routa Numbe	er, City or Town,	Stata, Zip Coo	de)
CENL		Donna Decker -	Friend		29A S	Stemmers	Run Road	, Baltim	ore, Man	ryland	21221
Baltimore, semit Pages 1 en appartment of Heal mportant: if item 2 my injury or other MGB.		20a. Method of Disposition		20b. l		osition (Nama of metory or other p		Date	20c. Location -		
Page entre		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		otate			1 Gardens	1_10_08	Davideo	nv:111a	Maryland
Britan .	-	21. Signature of Funeral Service		Lar		2. Name and Add		1-17-70	Davidson	IVILLE	, mary ranc
B FOR THE		17-	1	1	H	lnes-Rin	aldi Fune				
	1	man	- Jung	vue-	1	800 New	Hampshir	e Ave.,	Silver		
communication of		shock, or heart failure. Li	st only one cause on e	ach line.	in. Do not en	in the plone of a	lying, such as cardle	c or respiretory e	rest,	Inte	proximete erval Between eset end Death
Physician /Medical	П	Immediate Cause (Final	0		7	1	a- C.			011	Sot end Death
Examiner		disease or condition resulting in death)	a CO	NGE	STIVE	HEA	RTGA	ILURE		Y	EARS
	5	000000000000000000000000000000000000000		Due to (or as a conse	quence of):					1 -
D 10	E		_ b.	+1	VEU	MONI	A			1	1 DAYS
and Fra	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (d	or es a conse	quence of):					
60, be so		Cause (Disease or Injury	2 .	KE	ENAL	FAI	LURE				
68760, fillicate be ex 19 physician as the burial	edical	that initiated events resulting in death) Last	1	Due to (c	or as e consec						
44 E E	151		6	5	STR	OKE				- 7	WEEKS
death cer e attendir ed for use	Physician/										
. D e 2	/sic	Part II. Other eignificant condit	tions contributing to de	ath but not res	ulting In the u	nderlying cause	given In Part I.	23b. Dld 1	obacco uae co	ntribute to the	causa of death?
O to the	by Phy	HY	PERTE					10	Yes 2□ No	3 Probabl	y 4 Unknown
Deen per un per	Completed	M	ALNUT	RIT	TION				an autopsy med?	availab	autopsy findings ble prior to etion of cause th?
The law	E							101	es 2 No	1 ☐ Ye	es 2 No
Vital I	Bec	25. Was case referred to medic	al				26 Place of De	eth (Check only o		1210	22110
	0	examiner? 1 ☐ Yes 2X No	Hospital:	npatient 2	ER/Outpatie	nt 3 DOA	Other:	tome 5 ☐ Resid		er (Specify)	
Phy Phy	-	27. Manner of Death	28e. Date o	f Injury	28b. Time o				now injury occur		
On ding	tho	1 Natural 5 Pend 2 Accident inves	ling (Monti	h, Day Year)	Injury		/ork? ☐ Yes 2 ☐ No				
Division or Attending wher death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	mined 200. Flace	of Injury - At h	ome, farm, st fy)	reet, factory, offic	20	28f. Location (S City or Tov	Straat end Numb vn, Stata)	er or Rural Ro	uta Number,
and and and and and and and and and and	edical Ce	Check only 2 Medica	ing Phyaician: To the inference on the ba	best of my kno	wledge, deat	h occurred et the	time, date and place	a, and due to the	ceuse(s) and ma	inner as stated	d.
To the Hos within 24 h To the Fun completely		one)	and mann	er stated.							
5 N CO	2	29b. Signature and title of certif	Shon	nelle	M).		nse number		29d. Date signe		
7		PH	YSICIA	V		DL	10804		JAN	15,199	18
		30. Name and address of perso	n who completed cause	of death (Iter	n 23a) (Type,	Print) K6	EWAL K.	SHARI	MA MM		
		10620 GBA	2GIA AVE	3 #1	14.	SILVED	10804 EWAL K. SPRIN	6 MM	209	02.	
Sta	ate	31. Date filed (Month, Day, Yaa	1000 32.	ogistrar's Signa	ature						

MELESKI ARTHUR

	. Decedent's Name (First, Middle, La	ef)	Certificate of Death			Reg. No. UZ/00 2. Date of Death 3. Time of Death				
nysician Medical	ARTHUR	WALTER	M	ELESKI		JANUAR JANUAR	Day	q'ear	1:00 am	
iner 4	NORTH ARUND Social Security Number 6.5	y Number 6. Sex 7. Age (In yrs.		lest birthday) If Under 1 Year If		bb. City, Town, or Location of Dee Franchise Purity If Under 24 Hrs. Hours Min. Replace of Bi (Month, D) FEB. 27		irth ey, Year) 9. Birthplace (Stafe or F		
	Usual Residence of Decedent Oa. State 10b. County	1	l0c. City, Town or	Location			, 2000		Od. Inside City Limits	
1	MARYLAND ANNE		EDGEWATER			1 ☐ Yes 2 ☑ No				
1	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			
	215 OAKWOOD ROAD			21037			U.S.A.			
1	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in Armed Forces? 1 Yes 2X No If Yes, Give Yeer or Dates:			S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica			s or No- etc.) 14. Rece - American Indian, Black, White, etc. Specify: WHITE			
_	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) N/A		(Gi	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
1	12 N/A OWNER/ OF ERATOR					ame (First, Middle,	RETAIL SALES e (First, Middle, Maiden Surname) WSAKWSKA			
1	19a. Informant's Name/Relationship (Type, Print)(DAUGH	TER) 19b. Ma	iling Address (Stree		Rural Route Numb	er, City or Town,	, State, Zip	Code)	
	LINDA SUZANNE SC 0e. Method of Disposition 1 Burial Cremation 3 C 4 Donation 5 Other (Special	20b. Plece of Discemetery, c	215 OAKWOOD ROAD, EDGEWATER MD. 21037 sposition (Name of pate place) Date 1/19/98 EAKE CREMATORY, INC. BELITSVILLE, MD.							
dical Examiner	disease or condition esulting in death) Sequentially list conditions, I any, leading to immediate eause. Enter Underlying Cause (Disease or Injury hat initiated events esulting in death) Last	Corpany	ue to (or as a cons which constants and a de to (or as a cons	egoence of CM	Onigo	patty	,	2	Hmj Han	
Phy	Part II. Other significant conditions contributing to death but not resulting			ing In the underlying ceuse given in Part I.			23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Inknow			
Completed by							24a. Wes an autopsy performed? 24b. Were autopsy findings aveilable prior to completion of ceuse of death?			
5						10	Yes 2 no	10	Yes 2 No	
2	S. Was cese referred to medical exeminer? 1 Yes 2 No Nanner of Death 5 Pending investigation 1 Accident 3 Sulcide 4 Homicide Homicid	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
ledic	Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)								the cause(s)	
	May 10 8 au Why ms D-15860					0	1-19-98			
		HERLIHY, M.I	0., 325 1	OSPITAL I		EN BURN	E, MD.	21061		

Please Type or Print in Black indeiible Ink. Assure All Copies Are Legible.

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Vear MATHERS DONALD JOHN 10:00 AM 14, 1998 /Medical JANUARY 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth ANNE A Examiner 311 OAK MANOR DRIVE, APT. T-4 ARUNDEL GLEN BURNIE 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1√2 M 2□ F Months Deys Hours 61 Yrs. Director APRIL 6, 1936 MARYLAND 216-32-0363 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at MARYLAND ANNE ARUNDEL GLEN BURNIE 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 311 OAK MANOR DRIVE, APT. T-4 21061 II.S.A. Items 23e Funeral 72 hours efter deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 21215-0020 ō 1 ☐ Yes 2 ☐ No Specify: WHITE by 3 Widowed 4 Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A POSTAL EMPLOYEE POST OFFICE Maryland 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surneme) Pages 1 and 2 should be fill ment of Health and Mentel H Be WILLIAM AUBREY MATHERS Lo FRANCES CATHERINE treumetic GUTKOSKA 19e. Informeni's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) CATHERINE SCHMIDT (SISTER) 1400 GORDON COURT, FERNDALE, MARYLAND Baltimore, other 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from Stete ò Department of Important: If any Injury or once. 4 Donation 5 Qther (Specify) CEDAR HILL CEMETERY 1/19/98 BROOKLYN PARK, MD. 22. Name end Address of Fecility SINGLETON FUNERAL HOME, 21. Signature of 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, influre. List only one cause on each line. Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Finel Dilated Cardiomyopathy 6 years diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Examiner Diabetes Mellitus 9 years The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury thet Initiated events resulting in deeth) Lest Due to (or es e consequence ot):
Hypothyroidism buriel-tran and 8 years Division of Vital Records, P.O. Box 68760. Iding physician Physician/Medicai the r Due to (or es e consequence of): 98 atten ed by the a detached f Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? been signed by should be detac 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? page 2 After this certificate 1 Yes ≥ No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA in by the funeral 27. Manner of Death 1 Naturel 28e. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 0 within 24 hours of To the Funerel I Hospital 29a. Certifier Medical 🛣 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner steted. 29b. Sign 29c. License number 29d. Date signed (Month, Dey, Year) D14160 01/15/98 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Harjit Singh, M.D.

31. Dete filed (Month)

5410-A

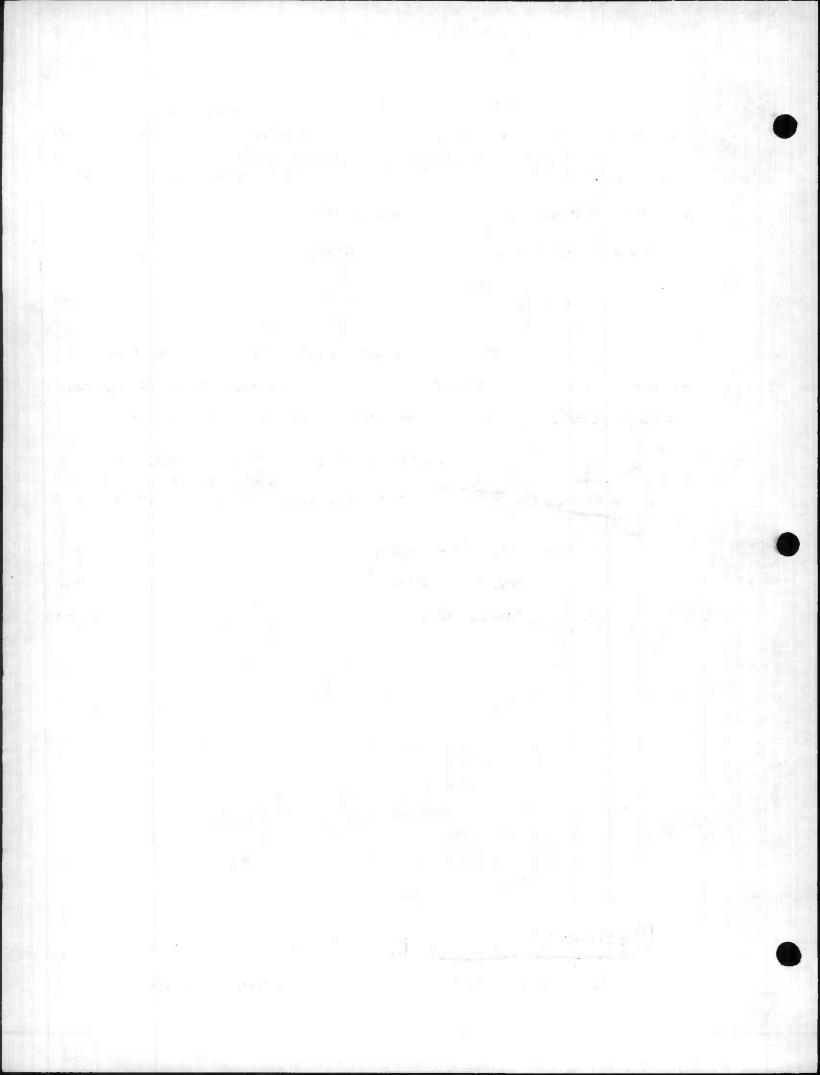
32. Registrer's Signeture

ma Davidson

Ritchie Highway

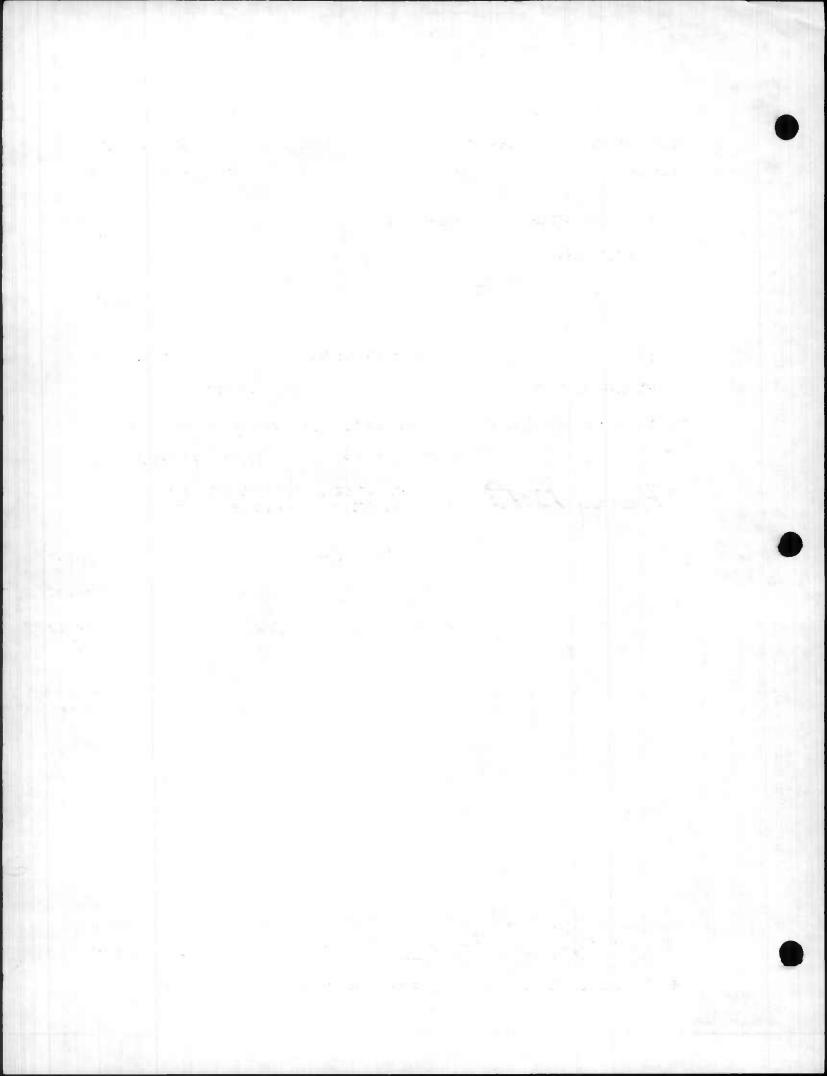
Mandell.

Baltimore, Md. 21225

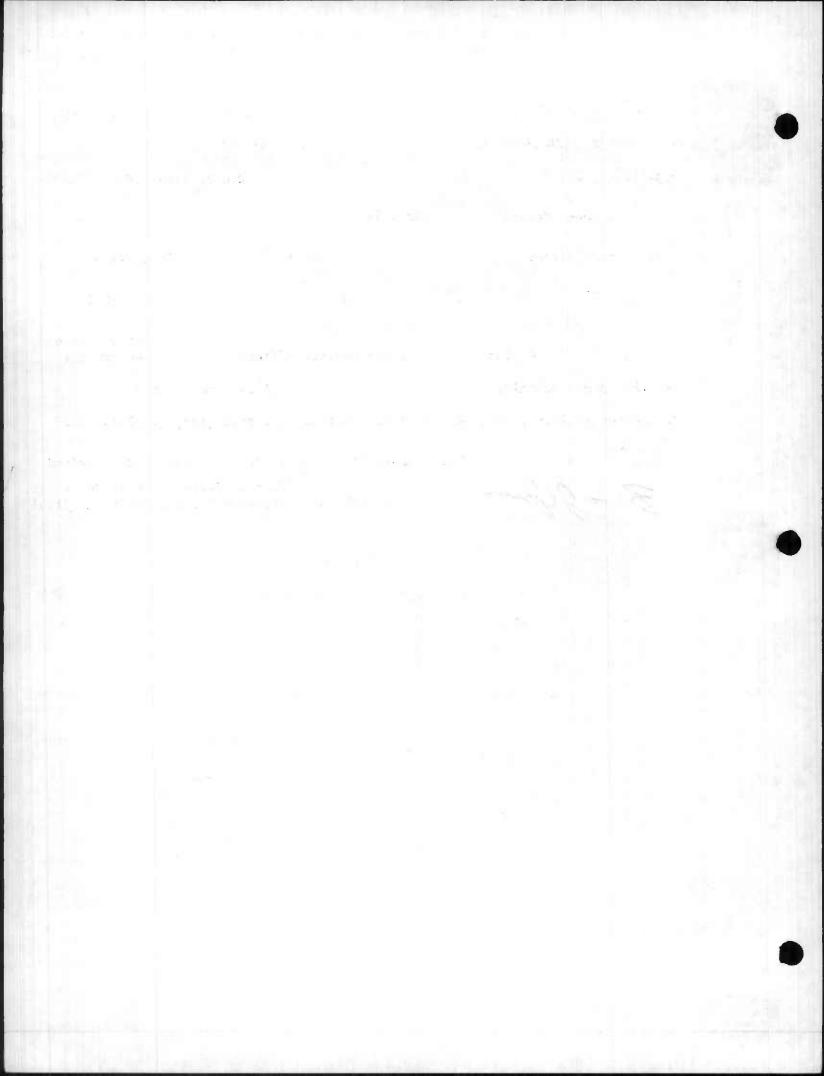


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

Dhuala		1. Decedent's Neme (Firs	st, Middle, Las	st)					2. Dete of D		Voor	3. Time of Dec
Physici /Medic		ANNI	E E. M	IURDEN						Dey 4 1998	Year	1935
Examin		4e. Fecility Name (If not in						4b. City, Town, o			unty of Deeth	1322
		ANNE ARUNDE	L MEDI	CAL CENTE	R			ANNAPOLI	S	ANNE	ARUNDE	et .
uneral		5. Social Security Number	r 6. S	ex 7. Age		last birthday)	If Under 1 Ye	ar If Under 24 Hi	s. 8. Date of B	irth		lece (State or Fo
irector		214-72-1345 Usual Residence of Dece		□ M 2□xF	94	Yrs.	Months	ys Hours Mi	DEC. 2	1903	MARYI	LAND
how		10a. State 10b.	County		10c. City	y, Town or Loc	cation				10	0d. Inside City LI
Hilled	ctor	MARYLAND AN	NE ARU	NDEL	ANN	MAPOLIS						1 Yes 2
or 28	Funeral Director	10e. Street end Number					10f. Zip Cod	е		10g. Citizer	of Whet Coun	try?
23a	ai	1999 FOREST	DRIVE				2140	1			US	
ams FLIS	ner	11. Meritel Status		12. Wes Decedent B Armed Forces?	Ever In U,	S. 13. W		of Hispenic Origin? (Suban, Mexican, Pue	Specify Yes or N	10- 14.	Race - America	
"natural", or itams 23a or 28a-1 show isotoal Examiner must be notified at	by Fu	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ D		1 Tes 2 N If Yes, Give Year or Dates:	No		☐ Yes 2 1		nto ritean, etc.)		Bleck, White, e	
ical	Completed	15. D	ecedent's Ed	ucation		16a. Deced	ent's Usuel Oc	cupetion		16b. Kind	of Business/Ind	dustry
Med	ple	Elementery/Secondary		de completed) College (1-4or 5-	(4)	life. D	OO NOT use re	cupetion ne during most of w tired)	orking			
than	TO.	8th	(0 12)	0	''	DAY C	ARE PRO	OVIDER		SELF	EMPLOYE	ZD.
d other	Be	17. Fether's Name (First,	Middle, Last)					18. Mother's N	ame (First, Midd			
markad matic e	To	WILLIAM	WATKI	NS				SARAI	EEPHUS			
is me		19e. Informent's Name/R	elationship (7	Type, Print)		19b. Mailing	g Address (Str	eet and Number or I			wn, Stete, Zip	Code)
27 r tr		DR. ELEANOR	HARRI	S (DAUGHTE	ER)	1999	FOREST	DRIVE AN	NAPOLIS	MD.	21401	
ltem r othe		20e. Method of Disposition		D 14 21	20b. PI	lece of Dispos	sition (Name of		Dete		ion - City or To	wn, Stete
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Funeral Director		215-12-6219 Usuel Residence of Decedent 10e. Stata 10b. County	x 7. Age (In yr. 78	s. last birthday) Yrs. City, Town or Loc	If Under 1 Year Months Days	BALTIMORE If Under 24 Hrs. Hours Min.	8. Dafe of Birth (Month, Dey Jan 22	, Yeer)	West Vi	(State or Foreign rginia nside City Limits
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be filed within 72 hours ital Hygiene. d other than "naturel", event, ine Medical Ex-	• Completed	15. Decedent's Edu (Specify only highest gred Elamantary/Secondary (0-12) 12 17. Fether's Name (First, Middle, Last)	cation le completed) Collaga (1-4or 5+) 4 plus	(Give k		oction during most of works d) ice Office 18. Mother's Neme	er	U	usiness/Industry nited S Governm	tates
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lan: T artificat ctor, pe	BeC	25. Wes case referred to medical examiner?				26. Plece of Deet			10.100	2,253,10
To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, page:	Certification: To	1 Yes 2 No 27. Menner of Deeth 1 Anaturat 5 Pending 2 Accidant Investigetion 3 Suicide 6 Could nof be 4 Homicide	1 Dinpatient 2 Din	28b. Time of Injury None home, farm, streity)	28c. Inju Wo M 1	Yes 2 □ No	me 5 ☐ Resid 28d. Dascribe h 28f. Location (S City or Tow	ow Injury occur	rred	ite Number,
To the Hospital within 24 hours: To the Funeral completaly filled	edicai	29a. Certifler (Check only one) 12 Certifying Physical Examination (Check only one)	elclen: To the best of my kn nar: On the basis of examin and menner steted.	owledge, deeth etion end/or inve	occurred et fhe ti estigation, in my d	ma, date end pteca, opinion, daath occurr	and due to the c ad at tha tima, c	euse(s) end ma lata and ptaca,	annar es statad. and dua to tha	cause(s)
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Sta	te	Morgan Howland 31. Dete filed (Month, Dey, Year)	5945 Wes 32. Registrer's Sign	tern Po	rint)	Baltim	ore, M	DZIZ C	09	April 100 m or of



State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of the **Physician** Month Helen Argatha Mullens January 20 1998 7:44 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Anne ARundel Medical Center Annapolis Anne Arundel if Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Aug 24 1 5 Social Security Number 9. Birthplece (State or Foreign Country) Vest Virginia 7. Age (In yrs. last birthday) **Funeral** 1□ M 3 T 212-36-0901 65 Yrs Director West Usual Residence of Decedent the Merylend 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 No 2 No Director Anne Arundel Annapolis 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 627 Ridgley Avenue "natural", or itams 23a 21401 United States permit. Pages 1 and 2 should be filed within 72 hours after death a Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "netural", or Items 23s any Injury or other traumatic event. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck. White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: by Specify White 3 X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home 17, Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Artie Jackson Mandy Smith 19e. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Judith Dean (Daughter) 627 Ridgley Avenue Annapolis, MD 21401

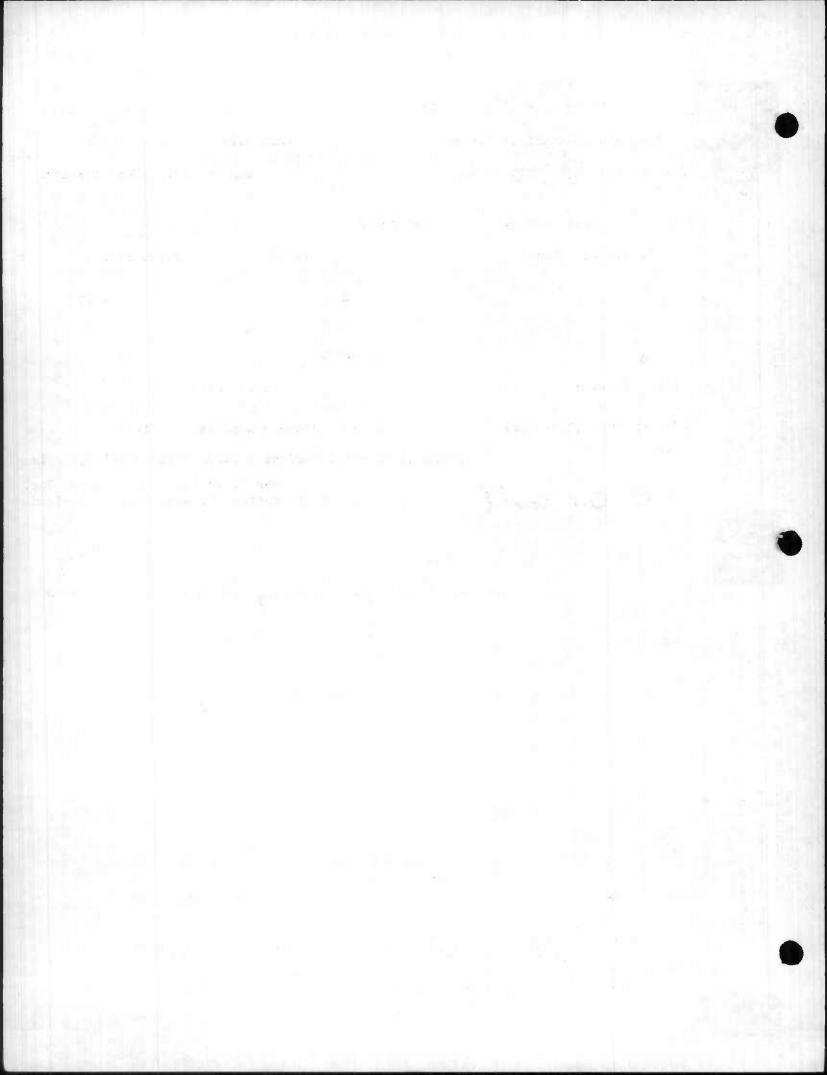
20b. Plece of Disposition (Neme of cemetery, cremetory or other place)

20c. Location - City or Town, Stete 20e. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removel from Stete Lakemont Memorial Gardens 1/23/98 Davidsonville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signeture of Funeral Service Lice 147 Duke of Gloucester St. Annapoilis, Maryland Ow 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Physiclan Preymour /Medical Immediete Ceuse (Finel diseese or condition resulting In deeth) Examiner Due to (or es e consequence of): Fulmorary Dryinge Examiner distructive - Hospital or Attending Physician: The law requires that the deeth cartificate be executed sty hours after death.

Funeral Director: After this cartificate hes been signed by the attending physicien and energy filled in by the funeral director, page 2 should be deteched for use as the burlansit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Lest Due to (or es e consequence of) P.O. Box 68760, Physician/Medicai Due to (or as e consequence of): Part ii. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 2K No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medicei examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Naturel 5 Pending Investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide n 24 hour.
The Funeral Direction To the Hospi within 24 hou To the Funer completely fil Testifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) EDEN MJ
32. Registrer's Signeture 1410 FOREST DR, ANNAPOLIS, MD 21403 1998 1998 31. Dete filed

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death JULY 4b. City, Town, or Location of Death cility Neme (If not institution, give stre Anna nne 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 24 Hrs 8. Date of Birth (Month, Dey, 6. Sex Birthpiece (State or Foreign Country) Deys 1□XM 2□ F Months Hours 12 1933 64 Pennsylvania 201-26-9195 Dec Usual Residence of Decedent 10b. County 10e. Stete 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Annapolis 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21401 2007 Chesapeake Road United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 Never Married Married White 1□ Yes 2XXNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) Coltege (1-4or 5+) 12 4 plus Sales Graphic Arts 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Allison Miller, Dorothy Wick 19a. tnforment's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Allison Miller, III (Son) 9687 E. Skinner Dr. Scottsdale, Arizona 85262 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Crematory 1/21/98 Brentwood, Maryland 22. Name and Address of Fecilityohn M. Taylor Funeral Home, Inc. ture of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in death) Due to (ocas s consequenca of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of) Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings aveilebte prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1. Neturet 1 Tyes 2 □ No 2 Accident

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-f show

7 is marked other traumatic event,

permit. Pages 1 and 2 should be filt Depertment of Haalth and Mental Hy Important: if Item 27 is marked oth ery Injury or other traumatic event 2008.

Director

Funeral

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e filed within 72 hours efter al Hygiena. other than "natural", or ita

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed Be

The law requires that the death certificeta be axecuted burial-transi pue Box 68760, physiciar the signed by the ettending p d be detached for use es P.O. Records, page 2 should peeu has cartificata Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this cartifica funeral director. Certification: To filled in by the

> State Registrar

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Medicai

31. Dete filed (Month, Day, Year) JAN 22 1998

6 Could not be

29c. License number

1 certifying Phyetclan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the best of exemination end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end manner stated. 29d. Dete signed (Month, Dey, Year)

Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

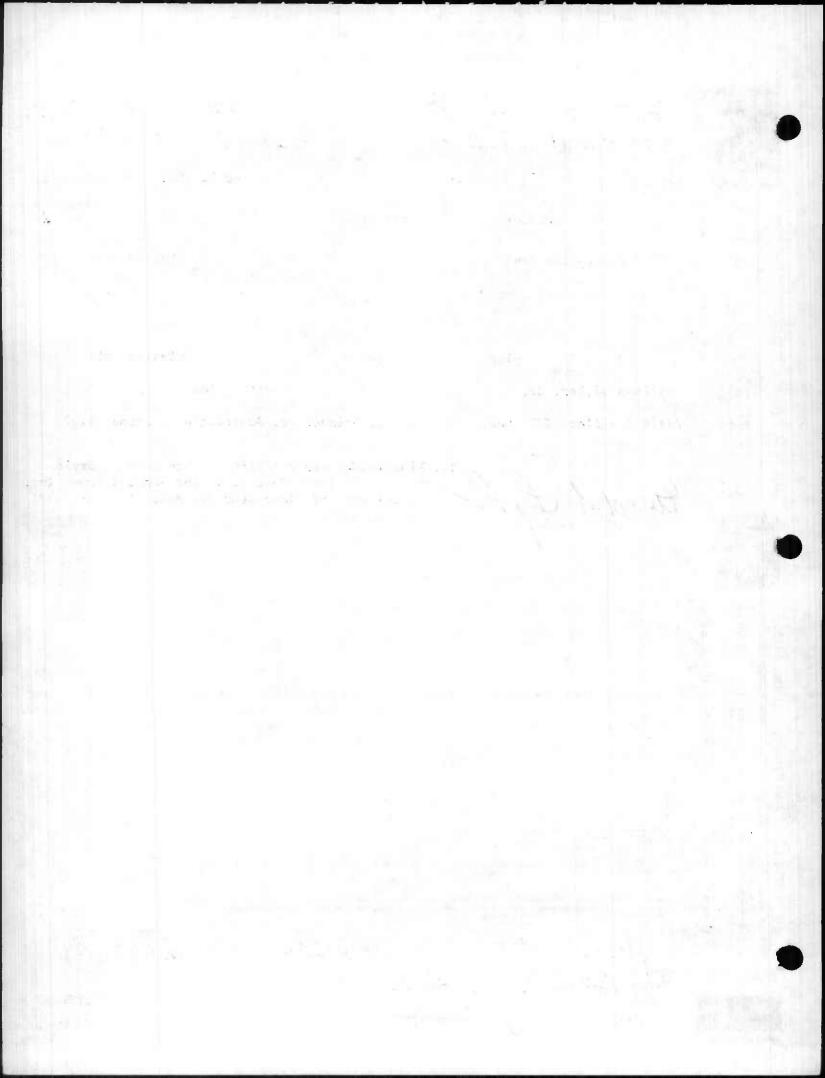
3 Suicide

29e. Certifier

4 Homicide

29b. Signeture end title of certific

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. Amended Item 28b, Per Phy. State of Maryland / Department of Health and Mental Hygiene 1/21/98, Carroll County, wil Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** MEDALIA EUGENE 18:00 JANUARY /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of, Deeth **Examiner** UNIVERSITY OF MARYLAND MEDICAL SYSTEM BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) **Funeral** Birthpiace (State or Foreign Country) 1 ₽M 2 □ F Months Deys Director 075-14-9626 Feb. 15 1920 New York Usuel Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Carroll Eldersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1280 Amy Court 21784 USA Funerai 12. Was Decedent Ever In U.S. Armed Forces? 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after 1 X Yes 2 No If Yes, Give 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ➡ No Specify: þ Specify: white 3 Widowed 4 □ Divorced Yeer or Detes: 1942-46 Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Marketing Manager Western Wood Products other Maryland 17. Father's Neme (First, Middle, Last) permit. Peges 1 end 2 should be file Department of Heelth end Mental Hy Important: If Item 27 is marked oth any injury or other traumetic evant 18. Mother's Name (First, Middle, Meiden Surneme) Be Joseph Medaglia Jenney Cherchia 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Victoria DeVilbiss (daughter) 1280 Amy Ct. Eldersburg MD 21784 Baltimore, 20b. Pleca of Disposition (Name of cemetery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Hope Cemetery 1/23/98 Hastings on Hudson NY 21. Signature of Funeral Servica Licansee 22. Name end Address of Fecility Haight Funeral HOme ian of Hayetzo P.O. Box 195 Sykesville MD 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feilure. List only one cause on each line. Approximate Interval Batween Onset and Deeth **Physician** /Medical Immediete Ceuse (Final END STAGE ORGAN FAILURE 2 months disease or condition resulting in deeth) **Examiner** Due to (or es e consequenca of) IAPHRAGM ATIC be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of): Box 68760, HORACIC HORTIC Physician/Medical Due to (or es e consequenca of): The law requires that the death certificate OTUR. VEHICLE P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PULMONARY CONTUSION, BILATERAL PREUMOTHORAX Division of Vital Records, Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? CORDNARY ARTERY DISEASE, CHRONIC OBSTRUCTIVE PHLMONARY 24a. Wes en eutopsy certificate has been 1 Yes 2 No 1 ☐ Yes 2 ☐ No DISEASE 25. Was case referred to medical exeminer?
1 ☑ Yes 2 ☐ No Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 inpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Menner of Death Dete of Injury (Month, Dey Year) 28b. Time of Injury Certification: 28c. Injury et Work? 28d. Describe how Injury occurred After Attanding 5 Pending investigation 1 Natural deeth. 1 Yes 2 No MOTOR OCTOBER 22 97 1:58 P M 2 Accident VEHICLE or Attand efter deeth Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide ROUTE 32 NEOUR BARTHOLOW ROAD STREET To the Funeral Completely filled Medicai Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner as steted.

Medical Exeminer: On the besis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end manner stated. 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date algned (Month, Day, Yeer) 30. Neme end eddrilles of person who cor increased cause of deeth (Item 23e) (Type, Print) 21201 H, BALTIMORE & GREENE ST., BALTIMPRE, MO MICHAEL LOWRY

State

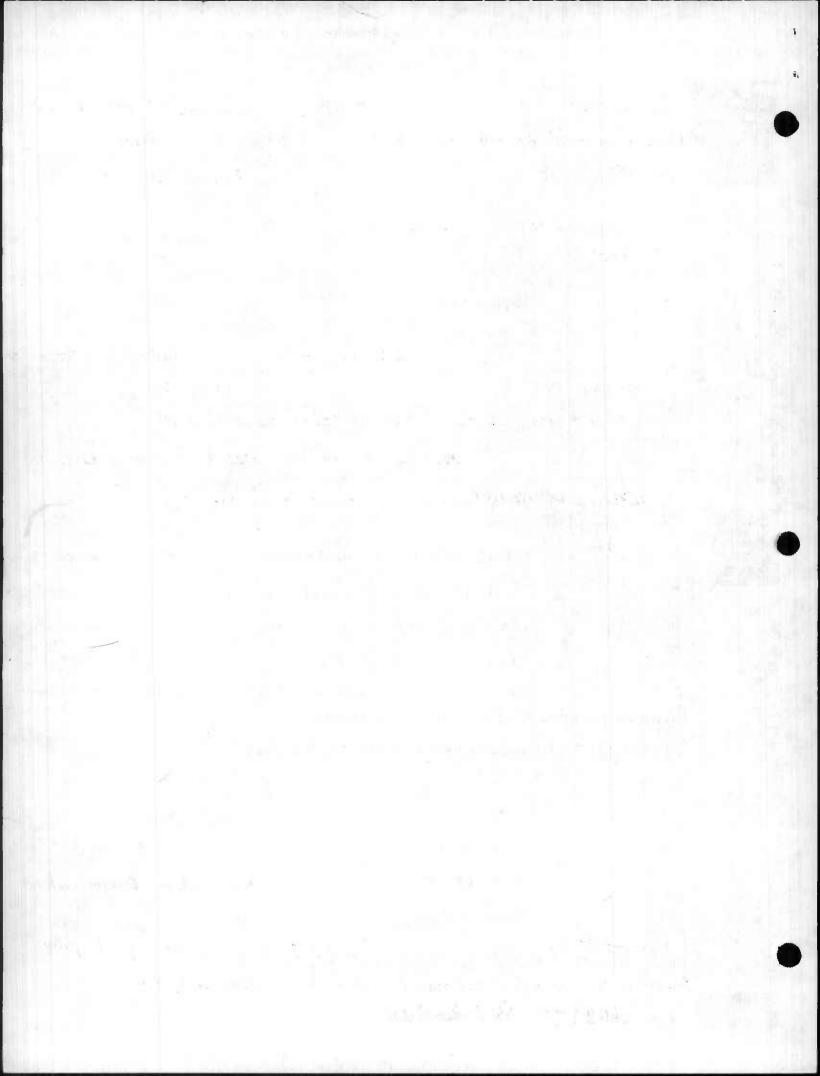
Registrar

31. Date filed (Month, Dey, Year)

JAN 2 1 1998

32 Registrer's Signeture

Tali Stwaler Redell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Item 1 Per PHY Film G762 8-5-98 rja

1. Decedent's Name (First, Middle, Last) Manikkavasagar Thuraisingham

1. Decedent's Name (First, Middle, Last) Manikkavasagar Thuraisingham Item 1 Per PHY Film G762 8-5-98 rja 3. Time of Death 2. Dete of Deeth **Physician** 40 A 18 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 17 M 2□ F Yrs. 219-29-3362 Director Oct 15 1918 Sri Lanka Usual Residence of Decedent r 28a-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Carroll Westminster Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 75 Washington Lane 21157 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indien. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Lankan-1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced ENCHAR Completed Peges 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natur ury or other traumatic event, tra Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banker Banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MANIKKAY ASAGAR Anchimuthu NAGAMUTHU VIRAMUTHA 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wife Thuraisinghan Kounsalan LARE WESTMINSTER, And 21157 75 SARASWATHY WASHINGTON 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) permit. Pege Department of Important: If any injury or once. Cherution HORRIA 21. Signature of Funeral Service Lice 22. Name and Address of Facility Pritts Funeral Home & Chapel or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, hist only one cause on each line.

Approximate interval Between Onset and Deeth 23a. Part1. Enter the die Physician /Medical Immediate Cause (Final disease or condition resulting in death) MULTILOBAR Preomonia Imonth Due to (or es a consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as e consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown Novinsulindependent diabeta. cangeshue by 24b. Were eutopsy findings evailable prior to heart Pailure 24a. Was an autopsy performed? Completed completion of cause of death? 2 0 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 1 Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

Examiner physician end the burial-transit The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 for use as signed by the a should l ate hes page 2 s r this certificate h or Attanding Physician: funeral After death. Director: / To the Hospital or within 24 hours aft To the Funeral DI completely filled in

the Maryland

72 hours efter death

THOMas K. Calvis Til mo

29c. License number D31660 29d. Date signed (Month, Day, Year) 19198

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 HOMAS K. GALVIN

295 somer me

WESTMIN SPER MO 21157

Registrar

Medical

31. Dete filed (Month, Day, Year)

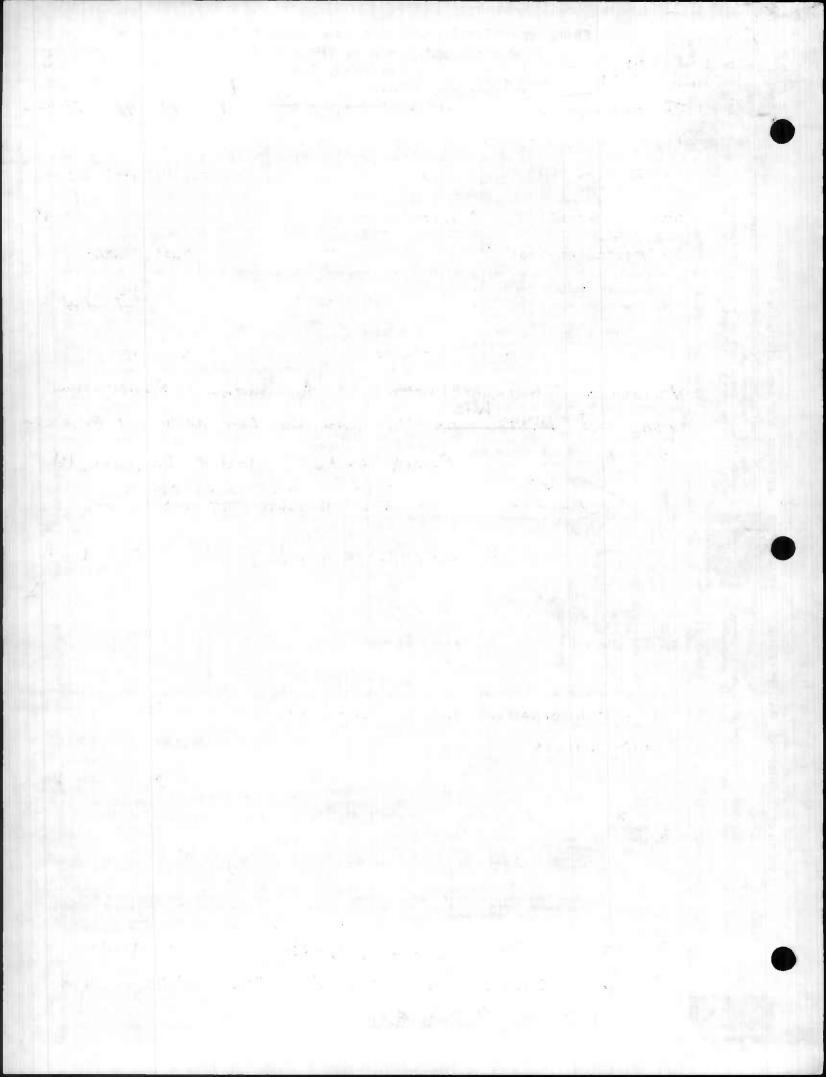
29b. Signature and title of certifier

29a. Certifier

(Check only one)

32. Registrar's Signature

Julia Stwilson Randell JAN 2 0 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** Day JAN 16, ALICE EVELYN MARTIN 1998 5:40 PM /Medical 4e. Fecility Nama (If not institution, give straet and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner LONG VIEW NURSING HOME MANCHESTER CARROLL If Under 1 Yaar If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Days 1 M & F Yrs Director 220-16-1474 88 OCT 16,1909 MARYLAND Usual Rasidance of Decadant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show Examiner must be notified at Director 1 Yas 2 No MARYLAND CARROLL HAMPSTEAD 10e, Street and Numbe 10f. Zip Coda 10g. Citizan of What Country? 6 230 4430 UPPER BECKLEYSVILLE ROAD 21074 USA Funeral Nems 2 12. Was Dacedent Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 72 hours efter 1 ☐ Yes 2 No If Yas, Giva Year or Detes: 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 ➡ No Spacify: by Specify: 3 Widowad 4 ☐ Divorced "naturel", WHITE Completed Pages 1 end 2 should be filed within 72 honen of Health end Mental Hygiene.
nnt: If Item 27 Is marked other than "natur.
Lry or other traumatic event, to a Med cal. 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) HOUSEWIFE OWN HOME 6 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maldan Surnama) Be NOAH IRVING RILL LULA ANNA DAVIDSON OF 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 s Department of Heath er Important: if Item 27 is any injury or other trau once. CHARLES E. RILL, NEPHEW 3425 MAPLE GROVE RD, MANCHESTER, MD 21102 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) HAMPSTEAD CEMETERY 1/20 HAMPSTEAD, MD 21. Signatura of Furreral Sarvice Licansea 22. Nama and Addrass of Facility ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batw Onsat and Death **Physiclan** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Altaher Examine Dua to (or as a consequence of) Examiner physician and the burial-transit that the death certificate be executed Sequantially list conditions, if any, laading to Immadiata ceusa. Entar Undarfying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of) attending p P.O. Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ been sig 24b. Wara autopsy findings available prior to Completed 24a. Was en autopsy pariormed? completion of causa of death? pege 2 s 2 No 1 ☐ Yas 2 ☐ 110 Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice stely filled in by the funeral director, I Be 25. Was cesa raferred to medical axaminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled edicai 1 🖵 Contifying Physicien: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 29a, Certifian Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. Licanse number 29d. Date signed (Month, Day, Year)

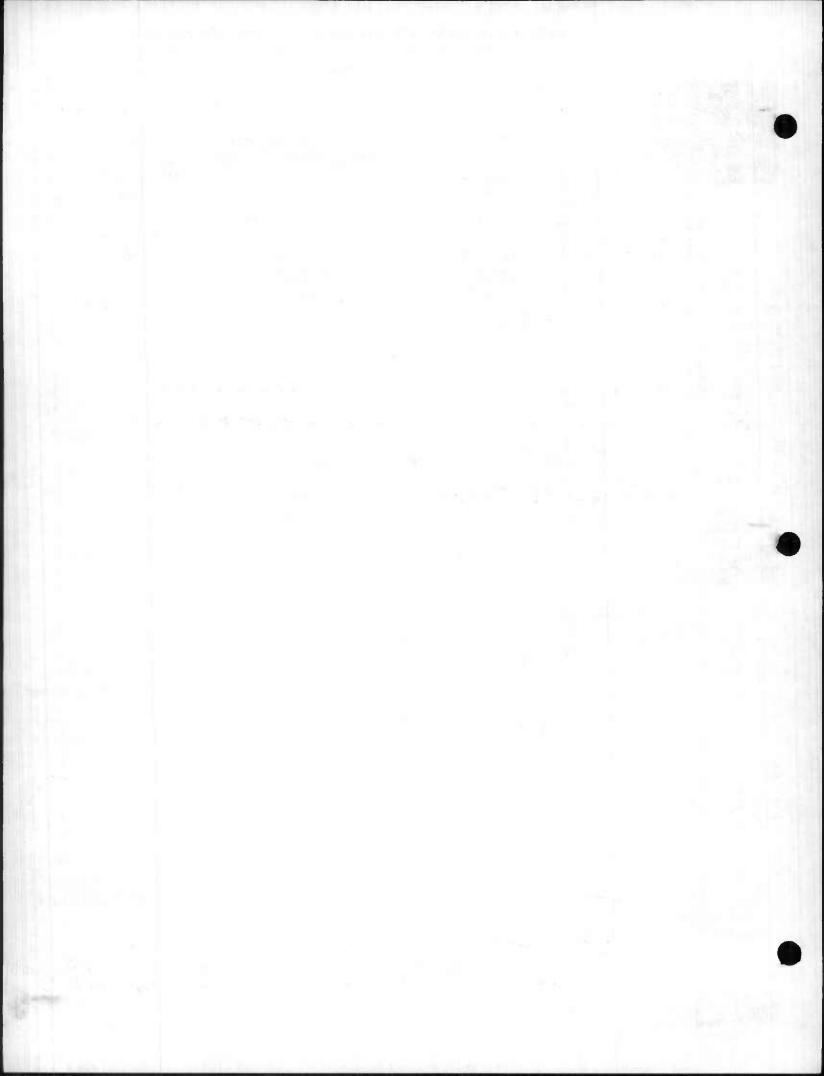
State Registrar 30. Nama and add

31. Data filed (Month, Day, Year)

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32. Resistrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Charles Lewis Millard 1998 6:00 PM January 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Sacurity Number If Undar 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10XM 2□ F Months Days Hours Min 216-16-0221 76 Yrs. Maryland Usual Residence of Deceden 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46169 Pleasant Drive 20653 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Year or Dates: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Road Worker State Government 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kalep Millard Mamie Bush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Belk Daughter 4110 Rocky Mount Drive Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion United Methodist Cemetery 1/16/98 St. Inigoes, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximately a complete the mode of dying, such as cerdiac or respiretory errest, Interval I Approximete Intervat Between Onsef and Death tmmediate Cause (Final disease or condition resulting in deeth) Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of ceuse of death? 1.7 1□ Yes 2DM 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Depatient 2 ER/Outpatient 3 DOA

Physician /Medicai Examiner

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To the Hospital or Attendir within 24 hours efter deeth. To the Funeral Director: At completely filled in by the fu

Examiner

Physician/Medical

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permit. Page Depertment of Important: If any injury or once.

Physician

/Medical

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Director

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Funeral

Director

tem 27 is marked other than "natural", or items 23s or 25s-f show other traumetic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filled within 72 hours effer in ant of Heelth and Mantal Hygiene.
Int: If Item 27 Is marked other than "natural", or Ite

Maryland 21215-0020

Baltimore,

P.O. Box 68760,

Records,

Division of Vital

CHARLES L. MILLARD

deeth with the Marylend

Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was cese referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Natural

5 Pending investigation

6 Could not be determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident 3 Suicide

4 ☐ Homicide

Physician: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examination and/or Investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and

29d. Date signed (Month, Day, Year)

30. Name and address death (Item 23e) (Type, Print)

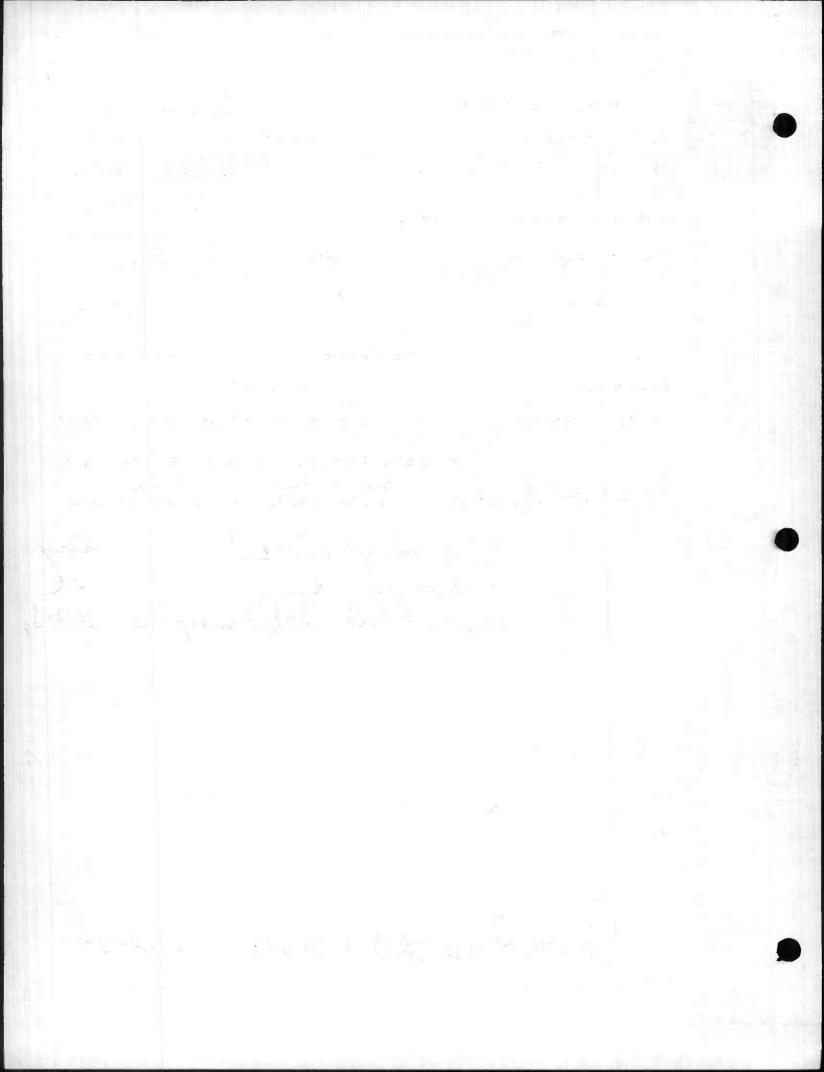
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JARBOE M.D. 31. Date filed (Month, Day, Year) JAN 15 1998

PHILIP J. BEAN MEDICAL CTR. HOLLYWOOD, MD. 20636 Smistrar's Signature Randall

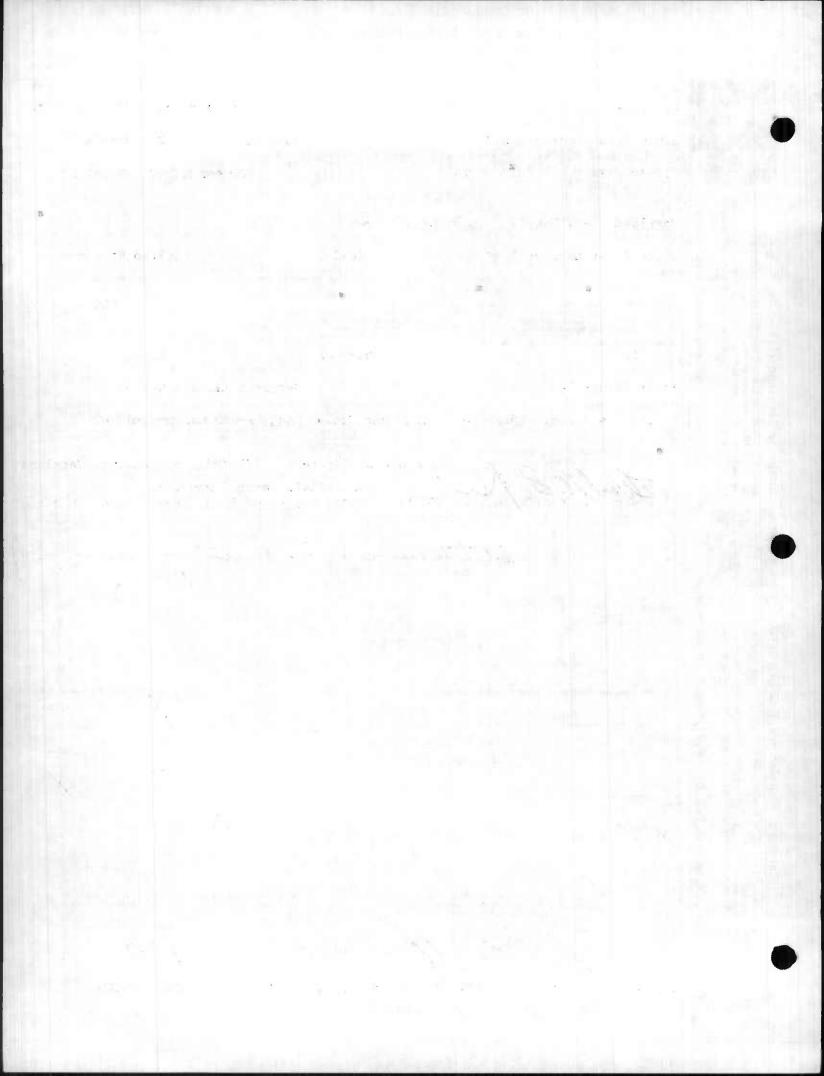
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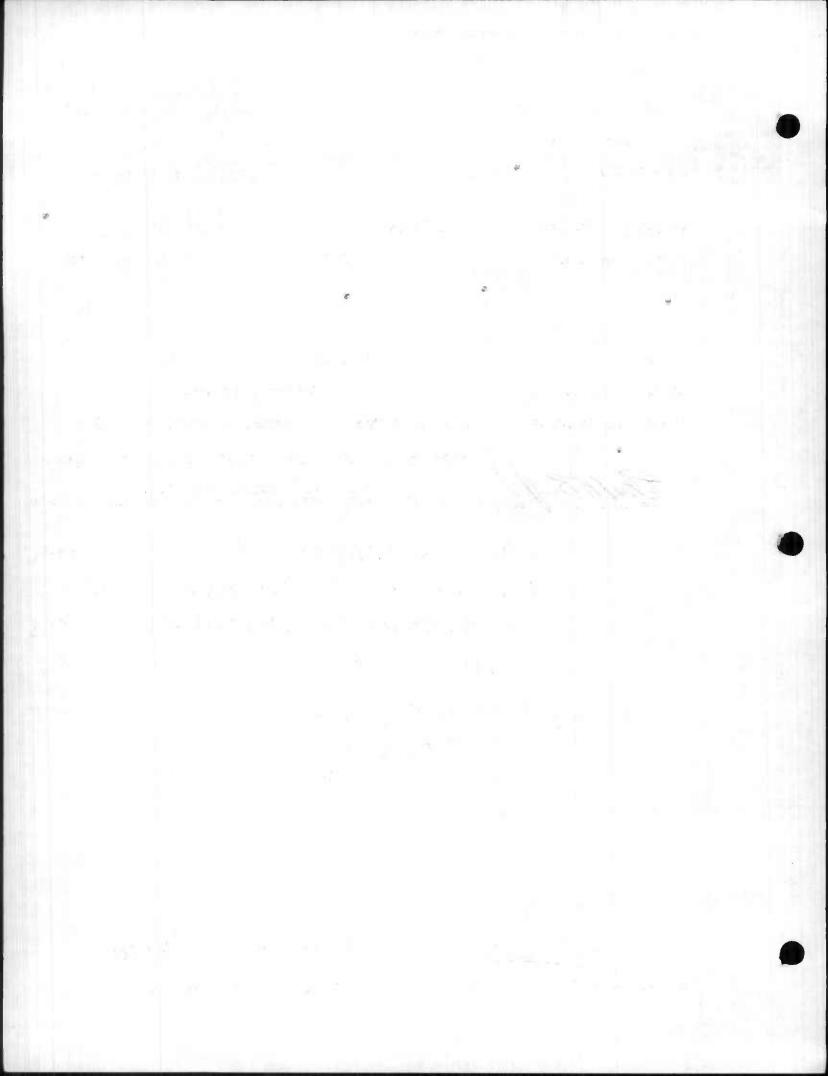


State of Maryland / Department of Health and Mental Hygiene

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Examiner	4e Fecility Neme (If not institution, git	ve street end number)			4	b. City, Town, o	Location of Death	4c. County	of Deeth	
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ma 22	11. Maritel Stetus	12. Wes Decedent Ev	er in U.S.			ispenic Origin? (Specify Yes or No-		e - American	
at, or items 23s or 28s-1 show Examiner must be notified at by Funeral Director	1 ☐ Never Married 2 ■ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Yeer or Detes:		tf Yes, spe		Specify:	Specify Yes or No- rto Rican, etc.)	Specify	k, White, etc	
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Mentel arked o atic ev	James Fenner Lee					Marga	ret Lill:	an Wath	en	
ond N bee	19a. tnforment's Name/Reletionship	(Type, Print)	19b. N	Melling Addres	s (Street e	end Number or F	Rural Route Numbe	r, City or Town,	State, Zip Co	ode)
27 is	Robert Lee Miles	, Husband	2602	O Point	Looko	ut Road,	Leonardtown	, Marylan	d 20650	
nent of Her int: If item iry or othe	20e. Method of Disposition		20b. Place of D	Disposition (Ne cremetory or	me of	101	Dete	20c. Location -	City or Town	, Stete
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kaminer		y's Hosp					Leonard				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Yeer Jay Laurence Millison 1998 January 27 /Medical 6:18 PM 4e. Fecility Name (If not institution, give street and number) 4b City Town or Location of Deeth 4c. County of Deeth Examiner St. Mary's Hospital Leonardtown St. Mary's 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

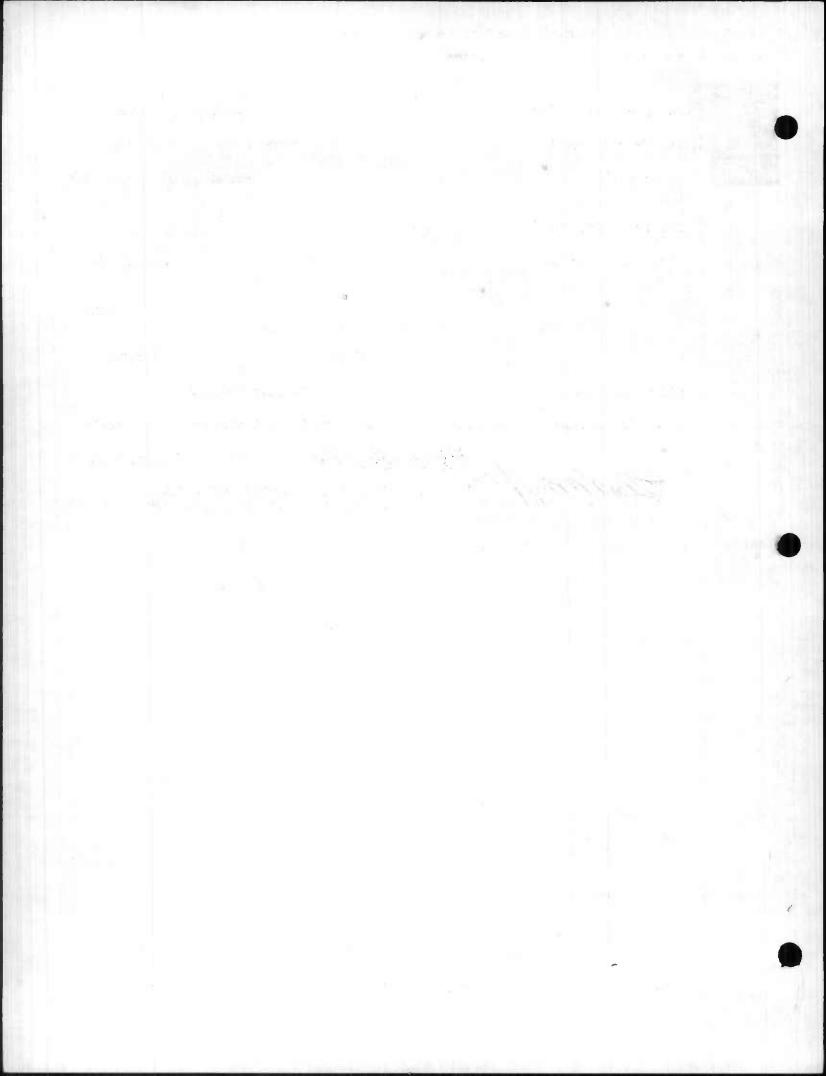
Months Davs Hours Min. 5. Social Security Number 8. Date of Birth (Month, Dey, Yeer) Birthplece (Stete or Foreign Country) **Funeral** Days 1■M 2□ F Yrs. Director 220-38-2186 64 August 5, 1933 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ■ No Maryland St. Mary's Lexington Park the 10e. Street end Number 10f. Zip Coda 10g, Citizen of What Country? 21881 Millison Lane Funeral 20653 United States 14. Race - Americen Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 ☐ Yes 2 ■ No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: Specify Completed by 3 Widowed 4 Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiana. Important: If Item 27 is marked other than 'any fujury or other treumatic event, the Mesonge. Elamentary/Secondary (0-12) College (1-4or 5+) Developer Real Estate 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Hiram Millison Carolyn Seebacher 19e. Informent's Name/Relationship (Typa, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Rachelle Millison, Daughter 21881 Millison Lane, Lexington Park, Maryland 20653 20e. Method of Disposition 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete Adath Israel Anshe 1 ■ Burial 2 □ Cremation 3 □ Removel from State 1/30/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Sfard Cemetery 22. Neme end Address of Fecility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23e. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failura. List only one cause on each line. Approximete Intervel Betw Onset end D **Physician** Carduac /Medical Immediate Ceusa (Final diseese or condition resulting In daath) Examiner Attending Physician: The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate ceuse. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Lest pue Box 68760. physician Physician/Medicai the Due to (or as e consequence of) attending for use es Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. LAWRENCE MILLISON Division of Vital Records, P.O. tha 23b. Did tobecco use contribute to the cause of death? signed by t 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed by 24a. Was an eutopsy performed? 24b. Wera eutopsy findings eveileble prior to completion of ceusa of daath? page 2 s 2 No 1 Yas 1 Tyes 2 No Be 25. Wes cese referred to medicel exeminer? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 20 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mennes of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Dascribe how Injury occurred Certification: 28b. Time of After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No daath. 2 Accident Director: 3 Suicide 6 Could not be detarmined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 or A 4 ☐ Homicide n 24 hours a Cartifying Physician: To the bast of my knowledge, deeth occurred et the tima, dete and plece, and due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daath occurred at the time, dete end plece, end due to the ceuse(s) end manner steted. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) D23634 1/28/98 30. Name end eddrass of person who completed ceuse of daeth (Item 23e) (Type, Print)

State Registrar

SHAH M.D. 31. Dete filed (Month, Dey, Yeer)

PHILIP J.BEAN MEDICAL CTR. HOLLYWOOD, MD. 20636 32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month anuary 0931 Minnie May Pilchard Merritt 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e. Facility Name (If not institution, give street end number) SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 1□M 25 F Deys Hours Min 219-34-2787 Yrs. 90 11-08 Virginia Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Va. Accomac Greenbackville 1 Yes 2 □ No 10e. Street end Number 10f. Zip Coda 10g. Citlzen of Whet Country? P.O. Box 141 23356 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify. 3X Widowed 4 □ Divorced white 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collage (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Raymond T. Pilchard Ina Mariner 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6235 Ocean Blvd., Chincoteague, Va. 23336 a of Disposition (Name of Date 20c. Location - City or Town, State Charlotte Snead, daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Othar (Specify) Union-Greenbackville1/17 Greenbackville, Va. 21. Sign Jure of Funeral Service Licensee 22 Name end Address of Fecility P.O. Box 87 Dennis Funeral Home, Snow Hill, Md. 21863 mus Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest shock, or heart feilure. List only one ceuse on each line. Approximete intervel Between Onset end Death Immediete Ceuse (Finel disease or condition resulting in daath) Due to (or es e consequence of) Sequantially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disaese or Injury thet Initiated evants resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Part !!. Other significant conditions contributing to death but not resulting in the underlying causa givan in Pert !. 23b. Did tobacco uea contribute to the cause of deeth? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes an eutopsy 0 1 ☐ Yes 2 ☐No 1 TYAS 2 No cance 26. Place of Deeth (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Othar (Specify) M☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of 28d. Describe how Injury occurred 27. Manner of Deeth 28c. Injury at Work? 28e. Dete of Injury (Month, Day Year) 5 Pending

physician end the burial-transit P.O. Box 68760 88 for use as ed by the detached signed by t should hes certificate director. of Aftar this funeral To the Hospital or Attending Pi within 24 hours efter death. To the Funeral Director: After th completely filled in by the funera Division

ment +

Physician/Medical Examiner Completed by Be 2 Certification: Medicai

Physician

/Medical

Examiner

Funeral

Director

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Director

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Haelih and Mental Hygiene.
ant: If item 27 is merked other than "natural", or items 23a or 28a-1 shount; If item 27 is merked other than "natural", or items 23a or 28a-1 shount; If it merked the word, it is fedical Examinat must be notified in

permit. Pagas Depertment of Important: If it any injury or o

Physiclan /Medical

Examiner

Baltimore,

25. Wes case referred to medical examinar? 1 Yes 2 No

> 1 SeNeturel 2 Accident 6 Could not be detamined 3 Suicida 4 Homloide

29a. Certifian

William

31. Date filed (Month, Day, Year)

investigation

28e. Plece of Injury - At home, farm, streat, fectory, office building, atc. (Spacify)

1 ☐ Yas 2 ☐ No

29c. License number

1 Certifying Physicien: To the bast of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end mannar as stated.
2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, daeth occurred at the time, dete end place, end due to the cause(s) end menner stated.

29b. Signature end title of certifier

30. Name end eddress of person who completed ceuse of deeth (Itam 23e) (Type, Print) M.O.

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

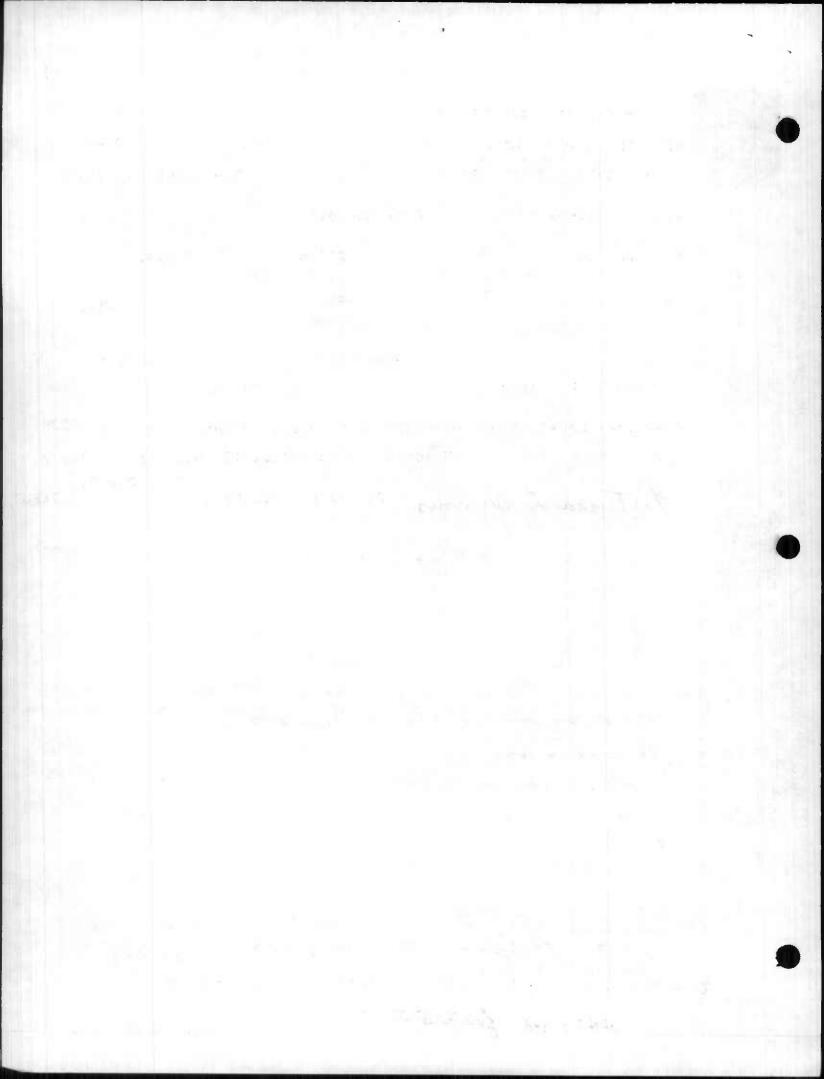
State Registrar

Robins

32. Registrer's Signeture Aulia Davidson

HEALTHAIN

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death Vanuary 14 1998 cation of Deeth 4c. County of Deeth David Neil Mason, Sr. 0810 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) XXM 2 F Yrs. 65 429-74-3966 10/4/1932 South Dakota Usuei Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Worcester Pocomoke City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 Front Street 21851 USA 12. Wes Decedent Ever in U,S. Armed Forces? YE Yes 2 □ No If Yes, Give Year or Dates:1951—1959 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American indien. 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐XMarried 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Postal Employee U.S. Postal Service 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Arthur R. Mason, Jr. Veryl Adams 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Front St., Pocomoke City, MD 21851 Ruby Mason (spouse) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 2 Buriai 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/19/98 Pocomoke City, MD Nelson Cemetery 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Holloway-Melson Funeral HOme Michael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximete Intervel Between Onset end Deeth tmmediete Ceuse (Finel diseese or condition resulting in death) or ca Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1□ Yes 2☑No 1□ Yes 2□ No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Important: If Item 27 Is any injury or other two

Baltimore.

Physician

/Medical

Examiner

Directo MD

Funeral

þ

Completed

8

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Funeral

Director

7 is marked other than "netural", or items 23e or 28a-f ahow traumatic event, the Medical Examinat must be notified at

1 and 2 should be filed within 72 hours aftar daath Haalth and Mantal Hygiena.

Examiner Physician/Medical by Be

2

Certification:

edical

29a. Certifier

(Check only one)

29b. Signeture and title of certification

physician and the burial-transit 88 usa a signed by the a cartificata has funeral Aftar

requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, Attending Physician: 24 hours after death. Funeral Director: Aft stately filled in by the fur 0

> State Registrar

1 Yes 2 No 27. Menner of Deeth 1 Naturel

5 Pending investigation 2 Accident 3 ☐ Suicide 4 Homicide

Could not be determined

28e. Date of injury (Month, Day Year)

1 Inpatient

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

2 ER/Outpetient 3 DOA

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner es steted. 2 Medicel Examiner: On the besis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29d. Date signed (Month, Dey, Year)

MS

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

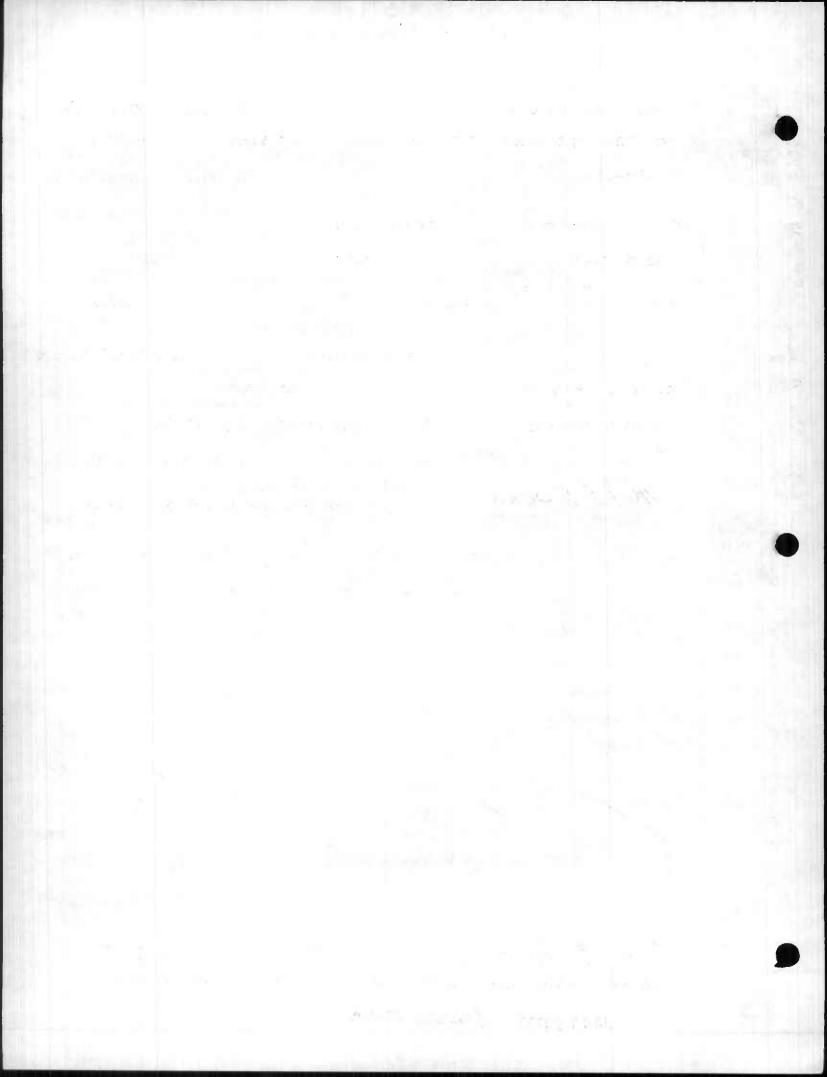
HEALTH WAY M.0

32. Registrar's Signature

KODINS

DHMH 16 Rev 6/95

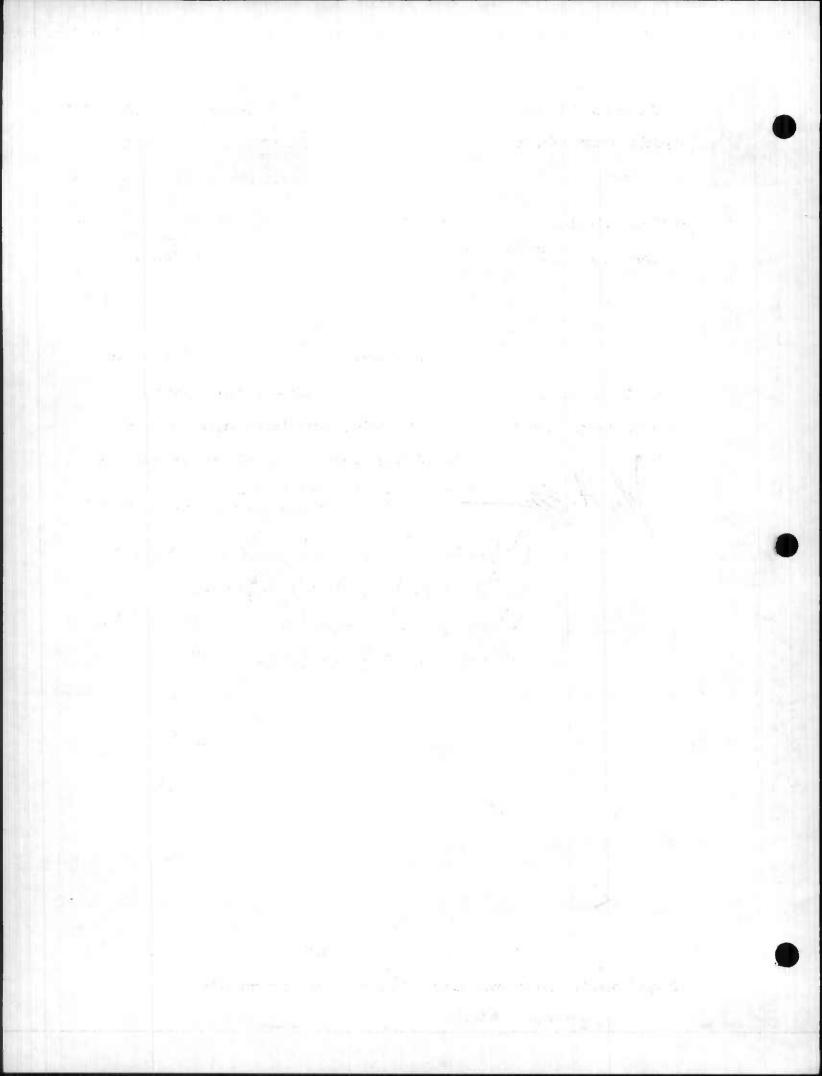
To the Hosp within 24 ho To the Fune complately fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Nam	e (First, Middle, L	ast)		Cer	tificate of	Death	2. Date of Dee	Reg. No.) (3. Time of Death
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/Medi			EDWARD	MADDUX ive street and numb	er)			4b. City, Town, or L	January ocation of Death	20 4c Cour	1998 hty of Death	4:50pm
Exami	ner	Physicians			.,			Ia Plata			rles	
Funeral		5. Social Security N			Age (In yrs. lest	t birthday)	if Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			place (State or Foreign
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the Marylar 28a-f show	cto	Maryland	Charles		La P	lata						1X Yes 2 □ No
th the	i e	10e. Street and Nu	mber One M	agnolia I	rive		10f. Zip Code			10g. Citizen o	f What Cou	ntry?
23e or	Funeral Director	Genesis	Elderca	re	72.1.0		20646			U.S.A	A.	
after dea	nei	11. Marital Status		12. Was Decede	as?	13. V	Vas Decedent of I	lispanic Orlgin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. R	aca - Americ	
	by	1 Never Merr 3 Widowed	ied 2☐ Married 4 ☑ Divorced		ZNo		☐ Yes ¾☐ No	Specify:	, , , , , , , , , , , , , , , , , , , ,		oity: Whi	
5-0 72 hc	pte	/Sna	15. Decedent's E	Education	1	8a. Deced	ent's Usual Occup	pation during most of work	ring	16b. Kind of	Business/In	dustry
T 8 1.3	Completed	Elementary/Seco		College (1-4	or 5+)	life. L	O NOT use retire	d)	· · · · · · ·			
d 212 dilled with Hygiena. ther than		7	400			Carpe	enter	.2 (1.2) (1.4)		Const		on
Maryland d 2 should be file th end Mental Hy 7 Is marked othe traumatic event.	Be	17. Father's Name	(First, Middle, Las	st)				18. Mother's Nam	e (First, Middle,	Maiden Sum	ame)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death MANNIS - Month Physician ESTEL :55 1998 20 ANUTIC /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner LA PLATA CHARLES COUNTY NURSING HOME **CHARLES** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. APRIL 16,1915 5 Social Security Number 9. Birthplece (State or Foreign **Funeral** 1**₩** M 2□ F WEST VIRGINIA 232-26-2266 Director Usuei Residence of Decedent the Merylend 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be northed at 1 ☐ Yes 2 📆 No Director MARYLAND **CHARLES** LA PLATA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10200 LA PLATA ROAD 20646 U.S.A. deeth Funeral permit. Pages 1 and 2 should be filed within 72 hours after deet Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumatic averages. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No if Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: WHITE ò 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) **FOREMAN** PEOPLES WAREHOUSE 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) JAMES HOWARD McMANNIS EFFIA MAE RUNION 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALMA R. RAWLINGS/NIECE 14953 BASSFORD ROAD, HUGHESVILLE, MARYLAND 20632 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Di 20c. Location - City or Town, Stete 1 X Burin TRINITY MEMORIAL GARDENS JAN.23,1998 WALDORF, MARYLAND 22 NATE HUNTT FUNERAL HOME, INC. **BROHAWN** M00053 P.O. BOX 156, WALDORF, MARYLAND 20604 Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intervei Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Fine Immediate disease or condition resulting in death) Examiner Examiner war Years physicien end s the burial-trans Sequentielly list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disaese or Injury that initieted events resulting in death) Last Years Physician/Medical Pert li. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to completion of cause of death? inveter mellitus Completed 24e. Wes en eutopsy performed? peen hes serile demention certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: efter death. Director: After this certific 25. Wes case referred to medical examiner?

1 Yes 2 No Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 20 funeral Certification: 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturei 2 Accident 5 Panding 1 Yas 2 No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled it 1 Medical Examiner: To the best of my knowledge, daeth occurred at tha tima, data and piace, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and menner steted. 29a. Cartifier Medical 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 4290

POB 203 BRYANS RP

, MD 20616

State Registrar 30. Name end address of person who completed cause of deeth (item 23e) (Type, Print)

32. Registrer's Signeture

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) SCAR H JERKINS, MD

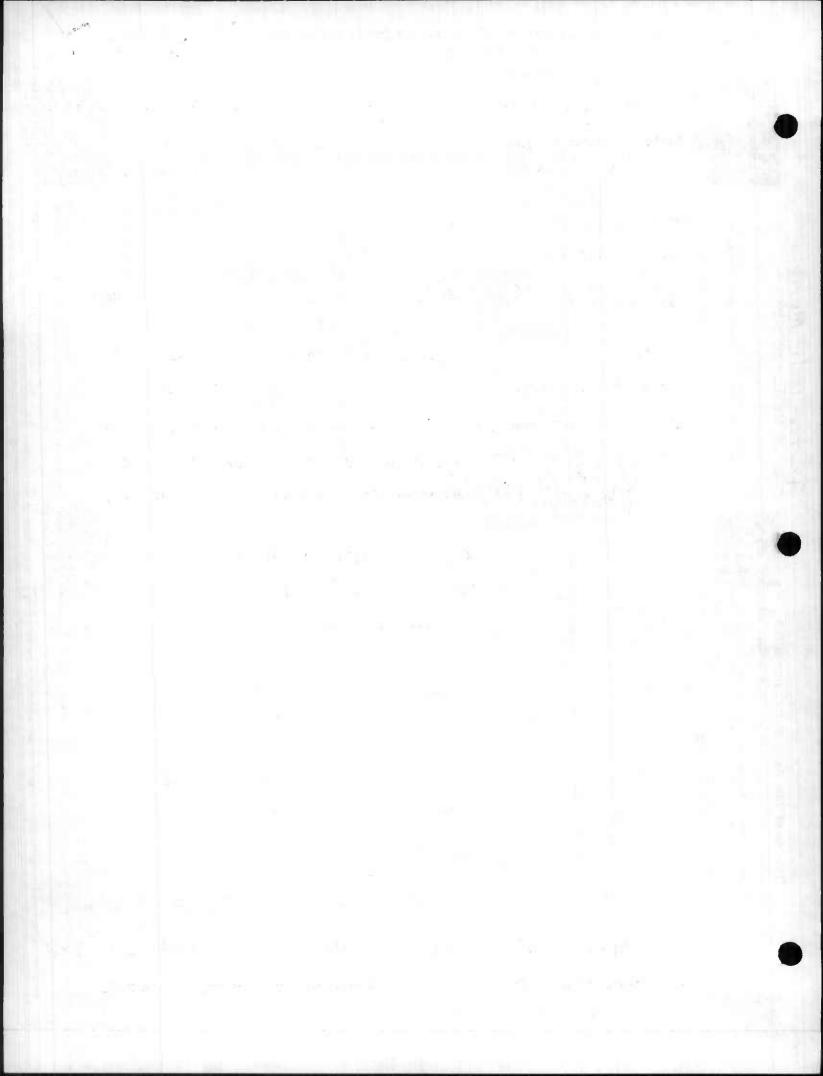
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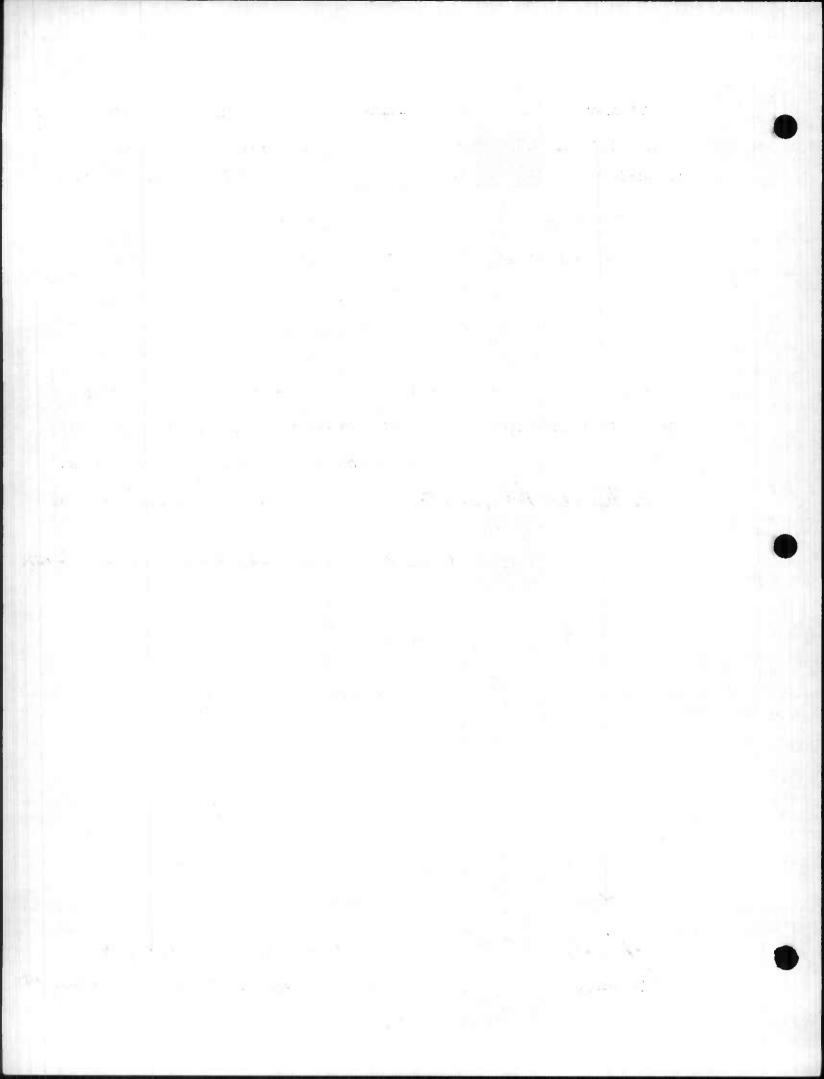
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Month SARAH 12:30 Am MAST dAn 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Grantsville Garrett Goodwill Mennonite Home If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1□ M 21XF Months Deys Hours 262-40-8585 Yrs 90 MAR. 1,1907 MARYLAND Usuel Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No GARRETT GRANTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? POB 310 DORSEY HOTEL ROAD 21536 USA Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Ricen, atc.) 12. Was Decedent Evar in U,S Armed Forcas? 14. Race - American Indian, Black, Whita, atc. 1 Navar Married 2 ☐ Married 1 Yes 2 No If Yas, Giva Yeer or Detes: 1 Yes 2 No Spacify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 NURSE HOSPITAL 17. Father's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumame) D. EL.I MAST AMANDA SCHLABACH 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) LESTER BEACHY GREENWOOD, DE. Box 53 19950 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Nourial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) GREENWOOD MENNONITE 1/17/98 GREENWOOD, DE 21. Signatura of Funaral Service Licensas 22. Nama and Addrass of Facility FLEISCHAUER FUNERAL HOME GREENWOOD, DE POB 502 19950 23a. Part1. Enter the disease, or complications that cause if the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each in ... Approximata fritarval Batween Onsat end Death Immadiata Ceusa (Final disaasa or condition rasulting in death) 200 yestive Weeks Due to (or as a consequence of): Due to (or s e consequence Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed?

Physician /Medical Examiner

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signed by t

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director.

funeral

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Hospital or Attanding Physician:
 24 hours efter deeth.
 Funeral Director: After this certific.

To the Within 2

P.O. Box 68760.

Records,

Division of Vital

Examiner

Physician/Medicai

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Certification:

Medical

injury or permit. Page Department of Important: if any injury or once.

Physician

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Director

Pages 1 end 2 should be filed within 72 hours efter death with the Meryland nent of Heelth and Mental Hygiene.
Int: If Item 27 is marked other than "natural; or Items 23s or 28s-f show ury or other traumatic svent, it is Medical Examinar must be notified as

Baltimore, Maryland 21215-0020

Sequantially list conditions, if any, laading to Immediata cause. Enter Undarlying Ceuse (Diseasa or Injury thet initieted avants rasulting in death) Last

27. Manner of Death

1 Natural

2 Accident

3 Sulcida

4 - Homicida

Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. emintia 10570m muic 25. Was case referred to medical examinet? 26. Plece of Deeth (C Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Data of Injury (Month, Day Year)

1 ☐ Yas 2 ☑ No

complation of ceuse of deeth?

1 ☐ Yas 2 ☐ No

hack only one)	
F Decidence	c DOther (Case)

Othar: 4 Nursing Homa 28d. Dascribe how Injury occurred

1 Yas 2 No

281. Location (Straet end Number or Rurel Routa Number, City or Town, Steta)

1 Certifying Phyeicien: To the best of my knowledge, daeth occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) 29a. Cartifier 29d. Data signed (Month, Day, Year)

28c. Injury at Work?

29b. Signatura and titla of certifiag 29c. Licansa number m

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28b. Tima of

1998 An

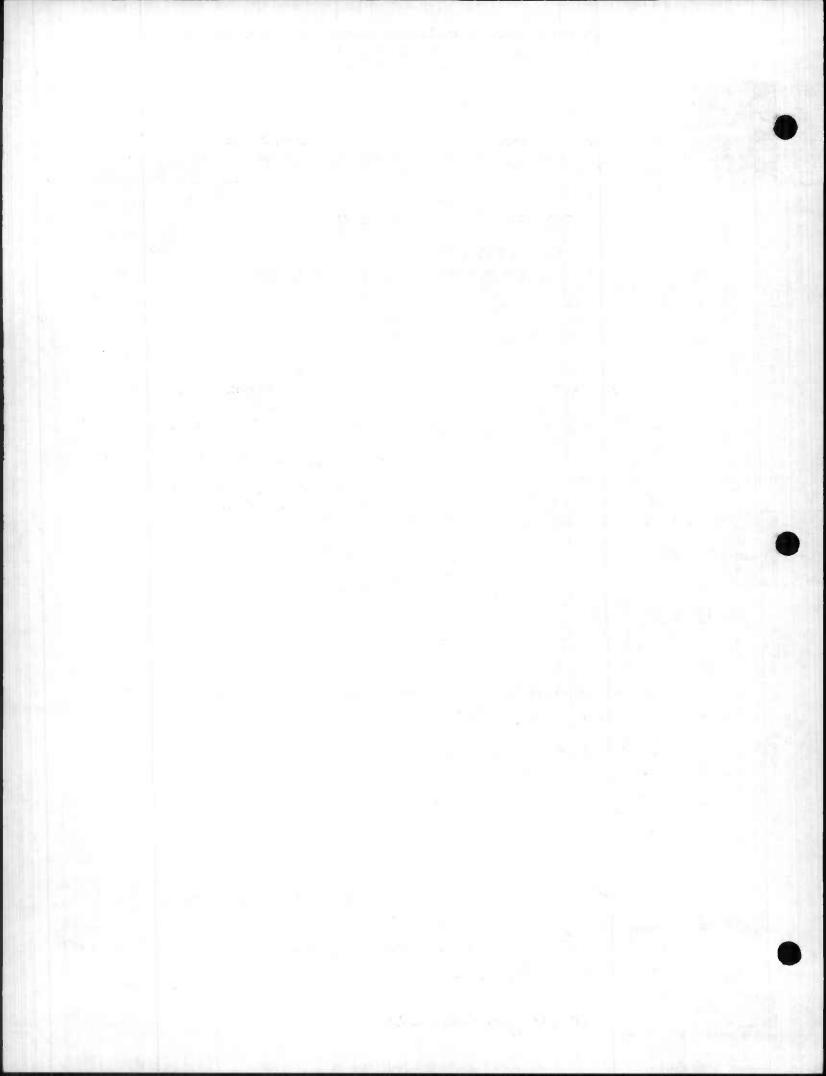
30. Name and address of person who complete ausa of death (tram 23a) (Type, Print) 9mis

31. Data filed (Month, Day, Year) 32. Registrar's Signatura

5 Pending Invastigation

6 Could not be datarmined

State Registrar

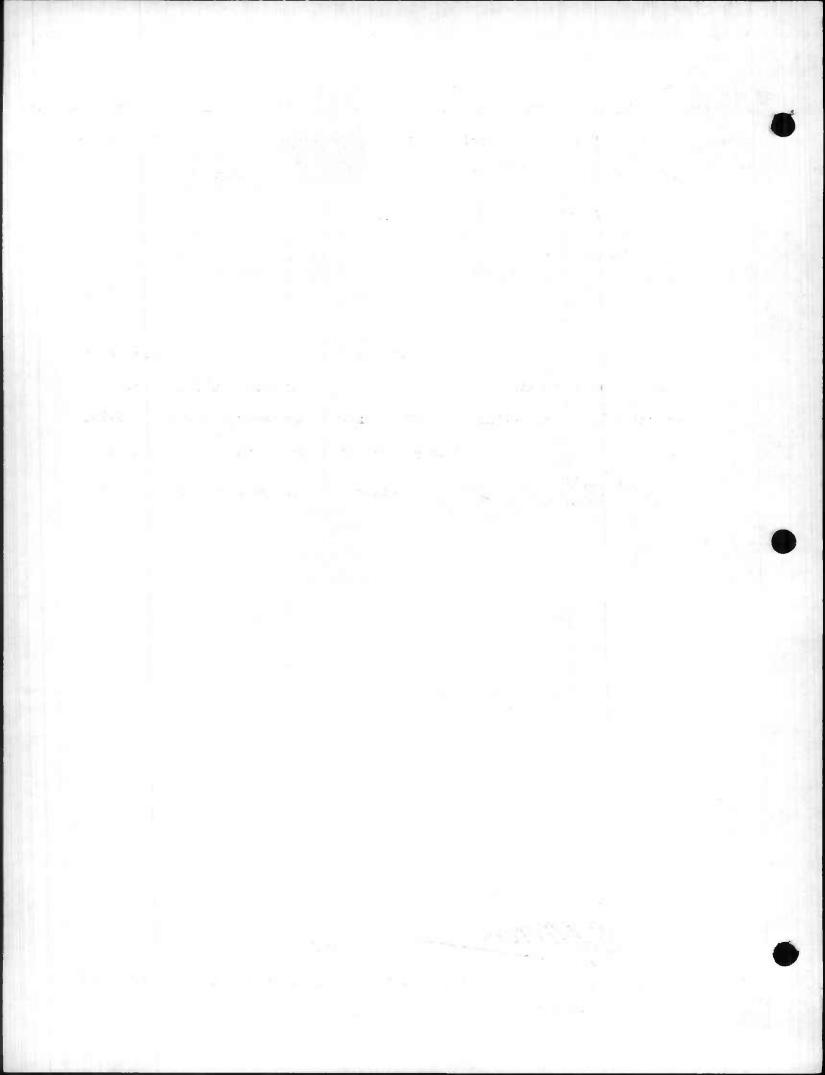


State of Maryland / Department of Health and Mental Hygiene 98

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Funera		5, Social Security Number	6. Sex 1M M 2□ F	7. Aga (In yrs		/) If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Dete of Bir (Month, De	v. Year)	9. Birth	npleca (Steta or Foreig untry)
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yla yla	2	John L. Murra	ч					Viol	la	A. McG	ee		
A Sand		19a. Informent's Name/Relation			19b. Mai	ling Address	(Street	end Numbe	r or Rur	el Route Numbe	er, City or Town	, Steta, Zi	ip Code)
To a supplement of the supplem		Connie J. Sat	ısman / Da		R.D.			88 A,	Mil	lsboro,	Delawa	re l	9966
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Division of Vital Re To the Hospital or Attending Physician: The Is within 24 hours effer death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	OF	29e. Certifier 1 Certif	Ing Physician: To th	e best of my kno	owiedae dee	th occurred	at the tir	ne dete end	i niace	and due to the	cause(s) and m	enner es	eteted
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10-1011111	edicai	(Check only 2 Medical Exa	miner: On the basis of examine	wiedge, deeth occurre tion end/or investigati	ed et the tin on, in my o	ne, date end plece, e pinion, deeth occurre	nd due to the ce d et the time, de	euse(s) end mei ete end pleca, e	nner as ste and due to t	ted. the cause(s)
D46979 1/18/98		29b. Signeture end tills of currently	ma				29	-		ey, Year)
		Car			D469	979		1/18/	98	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Collins P. Sein, M.D. 11345 Pembrooke Sq., Suite 104, Waldorf, MD 20603 State 31. Dete filed (Month, Dey, Year) 32. Registre's Signature		Collins P. Sein	, M.D. 11345	Pembrooke	Sq.,	Suite 10	4, Wald	orf, MD	206	03



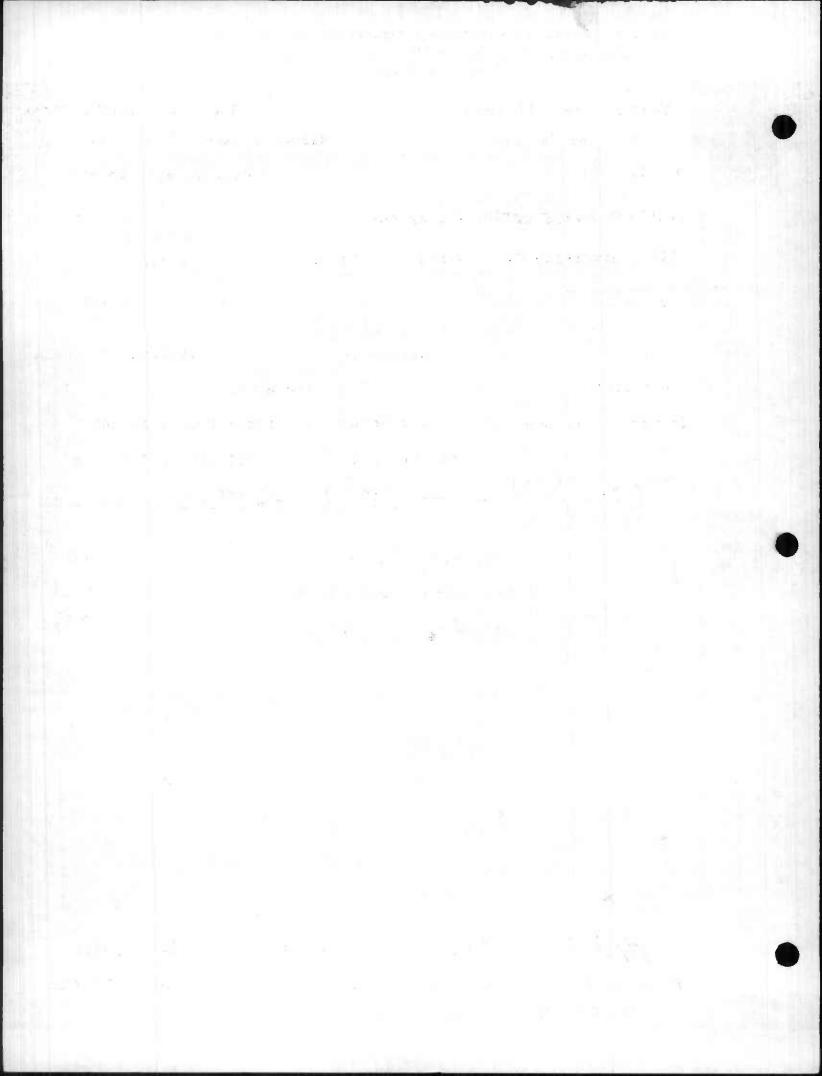
State of Maryland / Department of Health and Mental Hygiene 98 02010

			50 0400	Certificate of D	Peath	R	eg. No.	0 6	010
Dhuolo	ion	1. Decedent's Name (First, Middle, I	ast)	THE PARTY OF THE P		2. Dete of Deet	h		me of Death
Physic /Medi		Viola Aytch	Nichols			Jan.	11 19	98 7:	10P
Exami		4e. Fecility Name (If not institution, g	ive street end number)	4b	. City, Town, or Lo	ocation of Deeth	4c. County		
		The Memorial	Hospital		Easton		Talk	xot	
Funeral Director		5. Social Security Number 6. 218-20-9048 Usuel Residence of Decedent	Sex 1 M 2 F 7. Age (In yrs. 1	Ast birthday) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, 11/24/1	Yeer) .919	9. Birthplece (Si Country) Md.	tate or Foreign
and **		10e. State 10b. County	10c. City	y, Town or Location				10d. Insi	ide City Limits
the Marylar 28a-f show	ctor	Md. Queen	Anne	121 Newtown Rd.	Chester	, Md. 21	L619		Yes 2 No
th with the	al Director	10e. Street end Number 121 Newtown Re	d. Chester, Md	10f. Zip Code 21619		1	0g. Citizen of W	-	
within 72 hours effer death with the Maryland sinh. Jense "natural", or flams 23a or 28a-1 show the Medical Examiner must be inclined at	by Funeral	11. Merital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorcad	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2☒ No If Yes, Give Yeer or Detes:	S. 13. Was Decedent of His If Yes, specify Cuben		ecify Yes or No- Rican, etc.)	Bleck	e - American Indie k, White, etc. Black	an,
	Completed	15. Decedent's (Specify only highest g	Education rede completed)	16e. Decedent's Usual Occupet (Give kind of work done du life. DO NOT use retired)	tion uring most of work	Ing	16b. Kind of Bu	siness/industry	
filed within Thygiene.	Id I	Elementery/Secondary (0-12)	College (1-4or 5+)				77		
2012		10	A)	Factory Work		The state of	Food		
yiand ould be filed Mental Hygerked other	Be C	17. Fether's Neme (First, Middle, Last John H.	Aytch		18. Mother's Nemo		Aytch	3/	
S m s m	To	19a. Informent's Name/Reletionship Eva Fields		19b. Malling Address (Street er 121 Newtown	nd Number or Run		City or Town,		
			not D		. Nu. CI	•			
permit. Pages 1 an Depertment of Heal Important: if Item 2 eny Injury or other once.		20e. Method of Disposition 1√2 Burial 2 ☐ Cremation 3	C	lace of Disposition (Neme of emetery, cremetory or other pleca,)	Dete	20c. Location - I	City or Town, Sta	.te
. Pa Imen Jury		4 Donetion 5 □ Other (Spec	ify) C	hester - Union	Wesley 1	/17/98	Chester	r, Md 21	619
Depermit Depermit Import eny In		21. Signeture of Funeral Service Lic	A / A	22. Name end Address	of Fecility				
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		23a. Part1. Enter the disease, or co- shock, or heert feilure. List only	nplications that caused the death	. Do not enter the mode of dying,	, such es cerdiac	or respiretory erre	est,	Approx	ximete el Between
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/Medical Examiner		Immediete Ceuse (Finel diseese or condition	Sepsis	unth Urivary	1 roact	well	LOC .	tw	e day
CXAIIIIIIei		resulting in deeth)	Due to (or	os s consequence or.	_				day
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cate be executed physician end sthe burial-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury		r es consequence of):					U
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that the death cert ned by the attendin	Physician/	Dot li Other elevidicant avadition		•			Lancino Varia		
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as that igned b	by P	Kheunelou	a civillivis			1 Y	es 2□ No	3 Probably	4 K Unknow
requires been sign should be	Completed b	Staye in st	icral decul	itus ulcar.		24e. Was e		24b. Were euto aveileble p completior of deeth?	orior to
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death. ctor: A	fica	3 Sulcide 6 Could not	be 28a Place of Laine. At he	me, farm, street, fectory, office		28f Location (St	reet end Numbe	er or Rural Route	Number
if or Attending after death. Director: After d in by the fune	Certification:	4 ☐ Homicide determine	building, etc. (Specify)		City or Towr			
To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C			wledge, death occurred et the time ion end/or investigation, in my opin					use(s)
o the	Me	29b. Signeture end title of certifier		29c. License	number	2	9d. Date signed	(Month, Dey, Ye	ser)
F 3 F 8		\$ 50	78						
		30. Name end eddress of person who Syed I. Ali M.			con, Mai	ryland 2	1601		
Sta	ate	31. Dete filed (Month, Day, Year)	32. Registrer's Signet						
Regist	rar	JAN 131	998 Julia Sau	idson Randoll					

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State of Maryland / Department of Health and Mental Hygiene 9 8

Part Part	Decedant's Name (First, Middle, Last) Tetter Nathern See Facility Name (If not institution, give a tracet and number) See Facility Name (If not institution, give a tracet and number) Holy Cross Hospital	y of Deeth g omery 9. Birthplece (Stata or Fore County) Poland 10d. Insida City Lim 1 Tyes 2 The County? 2a - Amarican Indian, ck, White, etc. White usinass/Industry a Etz Chain na) Stata, Zip Code) D 20902 City or Town, Steta
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2 Accidant 3 Suicida 4 Homicide 28a. Placa of Injury - At homa, farm, straat, factory, offica building, afc. (Spacify) 28f. Location (Street and Number or Rurel Route Number of Town, State) 28g. Cartifign (Check only one) 29g. Cartifign Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29g. Cartifign Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier./ 29c. Licansa number 29d. Date signed (Month, Day, Year)		red
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(Check only one) 2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print) Michael Canada and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)	292 Cartifier Cartifular Physician: To the heat of my knowledge, death occurred at the time, date and place, and due to the occurred of the time.	anner as stated
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30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print) Michael Land Land Completed Cause of General Company According to Comp	29d. Date signed	a (Month, Day, Year)
30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)	1 Mided 1 29293 Jan 1	15, 1998
Michael I al MAD 10212 Command a CTI Com MAD 2 DC 02	30. Nama and address of person who completed cause of deeth (Item 23e) (Type. Print)	
	Michael Lincoln MD. 10313 Georgia Ave. Silver Spring Md.	20002



Physician/Medicai þ Completed Be 2

physician the 50 ettending USB 20 the 5 signed be del page 2 certificete funeral director. this After

Due to (or as a consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was cese refarred to medical Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No

> 28e. Date of Injury (Month, Day Year) 5 Pending Investigation

1/15/98

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Silver Spring Metro

28b. Time of 28c. Injury at Work? 1 Yes 2XXNo

28f. Location (Street and Number or Rural Route Number, City or Town, State) Silver Spring,

2 No

Montgomery Co.

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDJONE Mikus

111 Penn Street, Baltimore, Maryland 21201

nth, Day, Year) State Registra

29b. Signature anglittle of certifier

32, Registrar's Signature Luka Savidson

DHMH 16 Rev 6/95

24 hours

To the Within 2

Records.

of Vital Physician: Division

Certification: Hospital or Attending P
 24 hours effer death.
 Funeral Director: Affer t

edicai

27. Manner of Death 1 Naturel

29a. Certifier (Check only one)

2 XXAccident 3 Suicide 4 Homicide

6 Could not be

Injury 1:42

subject fell

26. Place of Deeth (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

24a. Was an autopsy

1 Wes

2□ No

24b. Were eutopsy findings available prior to completion of causa of deeth?

Unknown

3. Time of Death

1310PM

9. Birthplace (State or Foreign Country) New York

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 No

Day

17, 1998

4c. County of Death

Year

MONTGOMERY COUNTY

United States

Specify:

Optometry

14. Race - Amarican Indian, Black, White, etc.

White

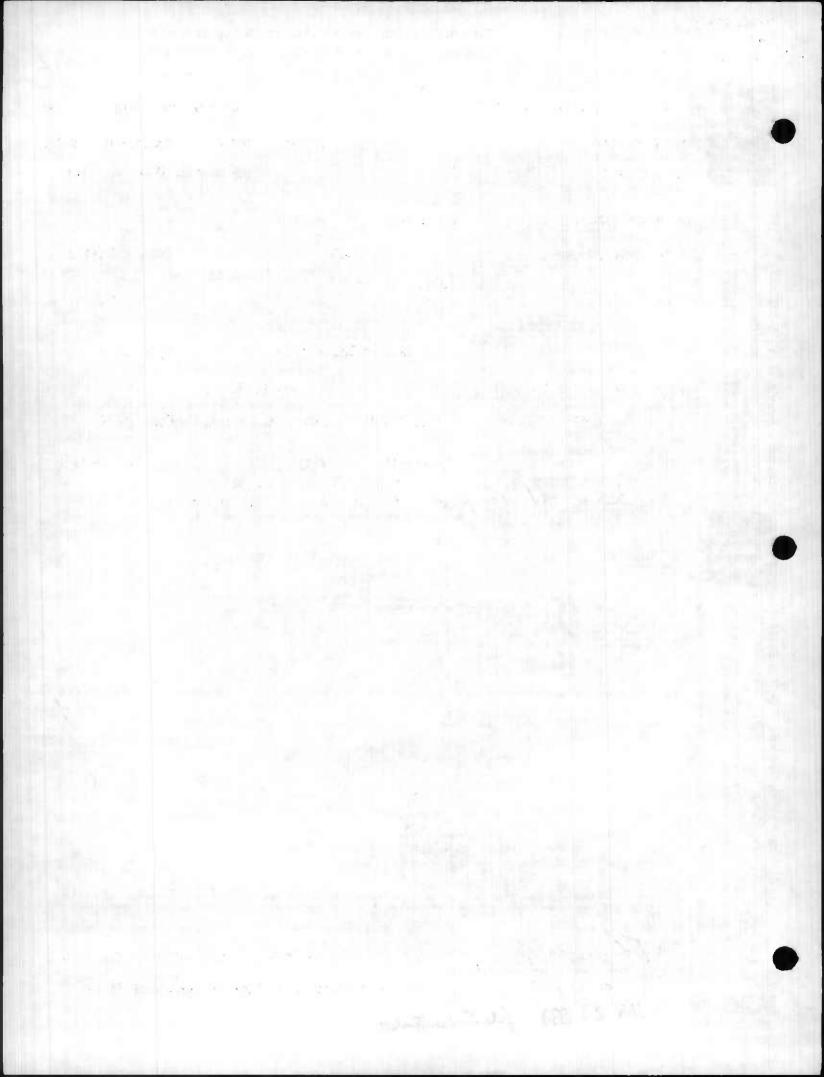
23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably

29d. Date signed (Month, Day, Year)

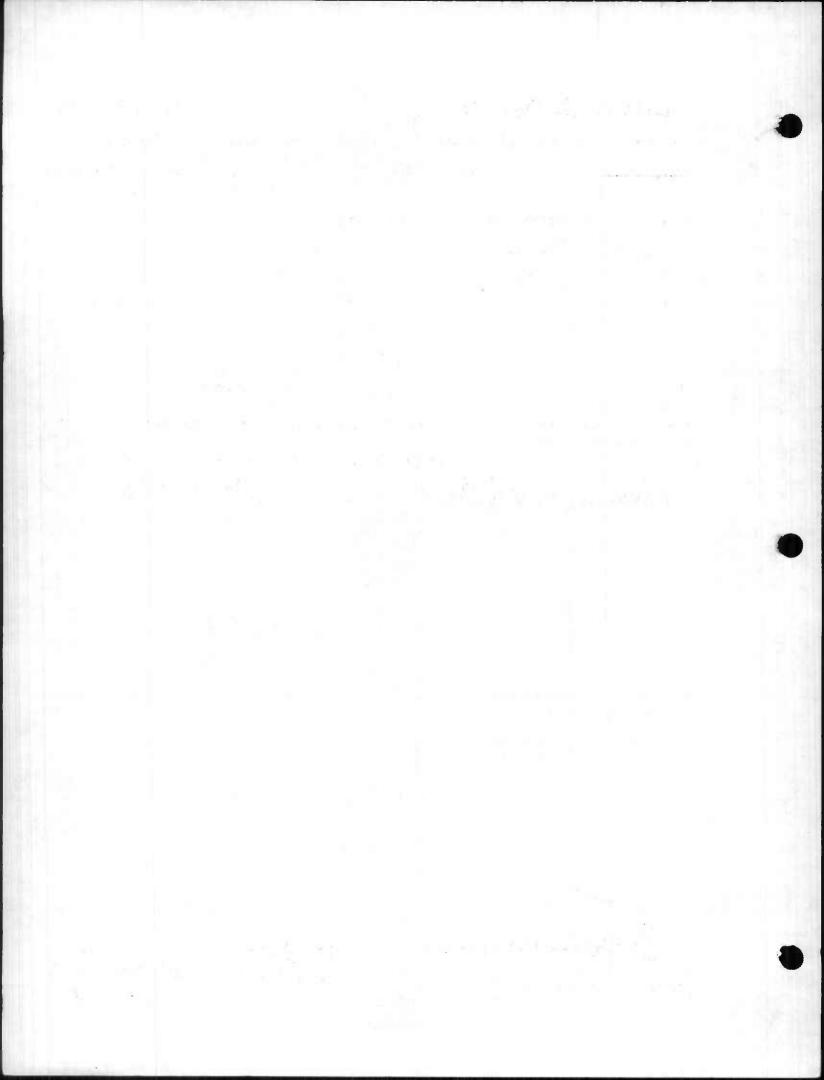
JANUARY 19, 1998

O.C.M.E.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 13

	#5 H	ER FH G762 8-4-98 WR.		C	ertificate of	Death	Reg	. No.	
Physic	ian	1. Decedent's Neme (First, Middle, Las					2. Dete of Deeth Month	Day Year 199	3. Time of Death
/Medi	icai	4e. Fecility Neme (if not institution, give	nelsc)[]		4b. City, Town, or L	January	4c. County of Dea	
Exami	ner	Carroll County (spital		Westmin		Carro	
Funeral Director		5. Spciel Security Nymber 6. Se	7. Age	(In yrs. last birthd	Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y Aug. 19,	9 Bi	hhplece (Stete or Foreign ountry) Minnesota
		Usuel Residence of Decedent					,		
anylan	_	10e. Stete 10b. County	. 1	10c. City, Town or					10d. Inside City Limits
the Marylar 28s-f show	ecto	Maryland Freder	TICK		Jnion Brid	ge			1 ☐ Yes 2 ☑ No
death with the Maryland me 23a or 28a-f show Limet be notified at	ral Dir	10e. Street end Number 11330B Clemsonvil	lle Rd.		10f. Zip Code 21	791	10g	U.S.A	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylei Department of Health and Mentel Hygiene. Department of Health and Mentel Hygiene Instructure: if item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Meritel Status 1 Never Merried 2 Married 3 X Widowed 4 Divorcad	12. Wes Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Yeer or Detes:	Ever in U,S.	3. Wes Decedent of It Yes, specify Cub 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Rece - Am Bleck, Whi	
72 ho netur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. De	cedent's Usuel Occupive kind of work done a. DO NOT use retire	pation during most of work	ding 16	b. Kind of Business	/Industry
vithin hen.	mpi	Etementery/Secondary (0-12)	College (1-4or 5	+)	e. DO NOT use retire farm wi	•		doing	
Hygie ther the	ပိ	17. Fether's Name (First, Middle, Last)			Idilli WI		e (First, Middle, Me	dairy	
d 2 should be file th and Mentel Hy 7 is merked oth traumetic event	o Be	Gustof Wolander					Carlson	odii comane,	
shound M mari	-	19e. Informent's Neme/Relationship (7	iype, Pnint)	19b. M	elling Address (Street	t end Number or Rui	ral Route Number, C	City or Town, Stete,	Zip Code)
and 2 alth a 27 is		Elmer C. Nelson/ s	son	113:	30B Clem	sonville	Rd. Unio	on Bridge	, MD 21791
ermit. Pagas 1 ar Department of Haa mportant: If Item : Iny Injury or other MCe.		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify			sposition (Name of cremetory or other place en Mem. Ga			c. Location - City of Finksburg	
mit. partm porter / injui		21. Signeture of Funeret Service Licens		41	22. Neme end Addre	1		_	
90 E 80		(atharine	1 Mani	Eler	6 E. Broa	dway Un	ion Bridg	e. MD 21	791
		23a. Pert1. Enter the disease, or comp shock, or heert feilure. List only	licetions that caused	deeth. Do not					Approximete Intervel Between
Physician		,							Onset end Deeth
/Medicai Examiner		Immediete Ceuse (Finel diseese or condition resulting in deeth)	· ilow	tri al	u al	Worle			Olyony
	10	resulting in deetily		Due to (or es e con	sequence of):				11.00010
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ettandin for usa	Physiclan/M		d						1
the et	sici	Pert II. Other significant conditions co	ntributing to death bu	t not resulting in th	e underlying cause gi	ven in Pert I.	23b. Dld tobe	acco use contribut	a to the cause of death?
thet the de ed by the detached							1 ☐ Yes	201√0 3□F	Probably 4 Unknown
na law requires thet the death cert is hes been signed by the ettendining a 2 shouid be detached for usa	ted by	Name and the					24a. Wes en o	eutopsy 24b.	Were autopsy findings aveilable prior to
28 %	Completed								completion of cause of deeth?
F # 8	Con						1□ Yes	2 No	1 Yes 2 No
Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical examiner?	Manakat /		lou		h (Check only one)		
5 00	2	ILI 195 ZILLINO	Hospitet: 1 Inpatier			4 LI Nursing Ho	ome 5 Residence		eclfy)
E je er	lon	27. Manner of Death 1 Neturel 5 Pending	28e. Date of Injur (Month, Dey	Year) 28b. Tim Inju	y Wo	ryet rk? Yes 2 □ No	28d. Describe how	injury occurred	
or Attending Phatter death. Director: After this in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e Plece of Inju	ny - At home farm	street, factory, office	1100 2 1100	28f Location (Street	et and Number or F	Rurei Route Number,
	ert	4 ☐ Homicide determined	building, etc		allout, lactory, ollico		City or Town,	Stete)	
To the Hospital within 24 hours a To the Funeral complately filled		29a. Certifier 12 Certifying Phy	sician: To the best o	f my knowledge, de	eth occurred et the ti	me, dete end plece,	end due to the ceu	se(s) end menner e	s steted.
in 24 he Fu he Fu	edicai	(Check only one) 2 Madical Exam	nar: On the besis of end menner ste	examinetion end/or ted.	tnvestigation, in my o	opinion, deeth occur	red et the time, dete	end plece, end du	e to the cause(s)
To the Within 2 To the comple	Σ	29b. Signature and title of certifier	1111-	231110	29c. Licens	se number	29d	. Dete signed (Mon	th, Dey, Year)
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		00 None and address of an artist	ampleted source of d	oth (Itam 22a) (Tu		1	1 0	.2 2	3
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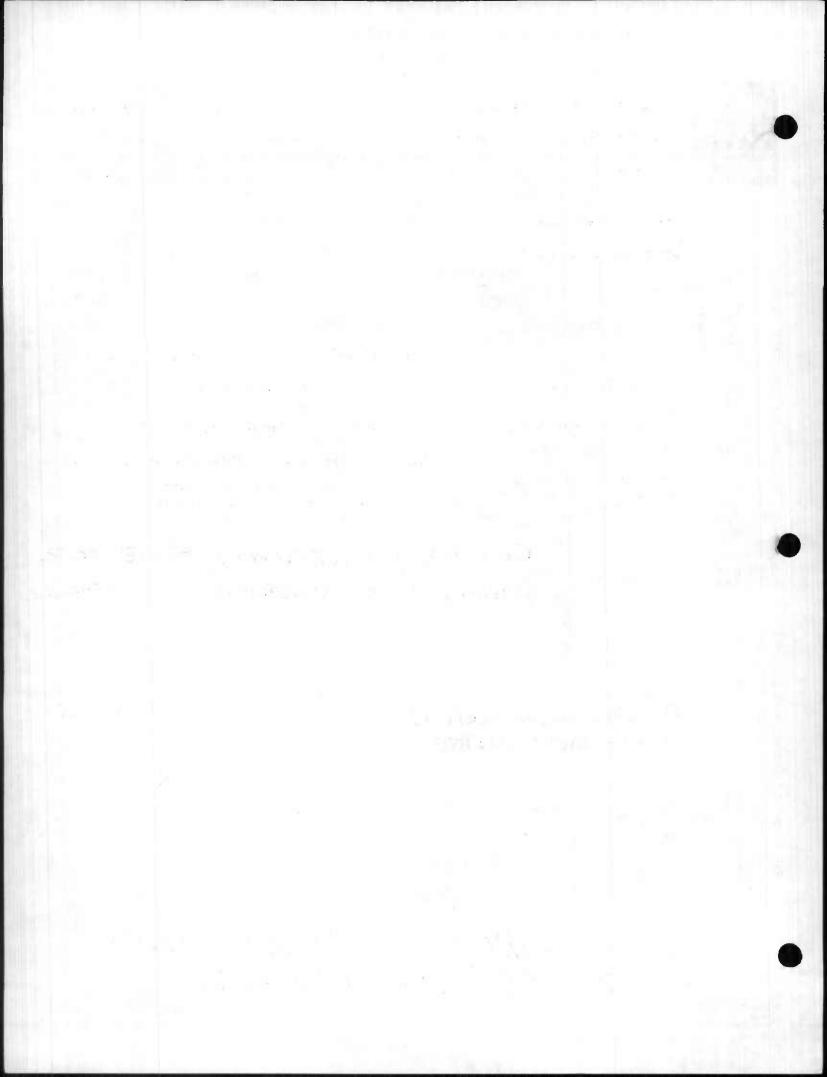


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death **Physician** Month DOROTHY CLEVELAND NASH January 19 1998 1220 pm /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shore Nursing & Rehab Center Caroline If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 F 578-26-0263 85 Yrs. March 4, 1912 Washington D.C. Director Usual Rasidence of Dacedani the Maryland 10a Stata 10h County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mod cal Examinat must be not that at 1 ☐ Yas XX No Director Caroline Denton 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 280 Campground Rd. 21629 USA death Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas ② No If Yas, Giva Yaar or Datas: Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 □ Navar Marriad 2 □ Married Saltimore, Maryland 21215-0020 1 ☐ Yas XX No Specify: white þ 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neny Injury or other traumatic event," It has Elamentary/Secondery (0-12) College (1-4or 5+) Classified C.I.A. U.S. Gov't 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Perry Cleveland May Shaw Cleveland 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Joan P. Collomb/daughter-in-law 1008 Sextant Ct., Annapolis, MD 21401 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 € Burial 2 Cramation 3 Ramoval from Stata 1/23/98 Church Hill, MD 4 ☐ Donation 5 ☐ Othar (Specify) Church Hill Cemetery 22. Name and Address of Facility Fleegle & Helfenbein Funeral Home 21. Signatura of Fonaral Sarvice Licensas ca 106 W. Sunset Ave., Greensboro, MD 23a. Pertf. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting In death) CORONARY INSUFFICENCY, ACUTE
Dua to (or as a consequence of): Examiner Examiner OVONDRY ADTERIOSCLEROSUS

Dua ((or as a consaquance of): sician and buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting In daath) Last physician a the buriel Box 68760, Physician/Medical Dua to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Records. P.O. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CEREBRO ASTERIOSCLEROSIS by ALZHEIMERS DISEOSE 24b. Ware eutopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed this certificate 1 ☐ Yas 2 ☐ No Division of Vital 25. Was cesa rafarrad to medicel axaminar? Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 ☐ Yes No 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred al or Attanding P sefter death.

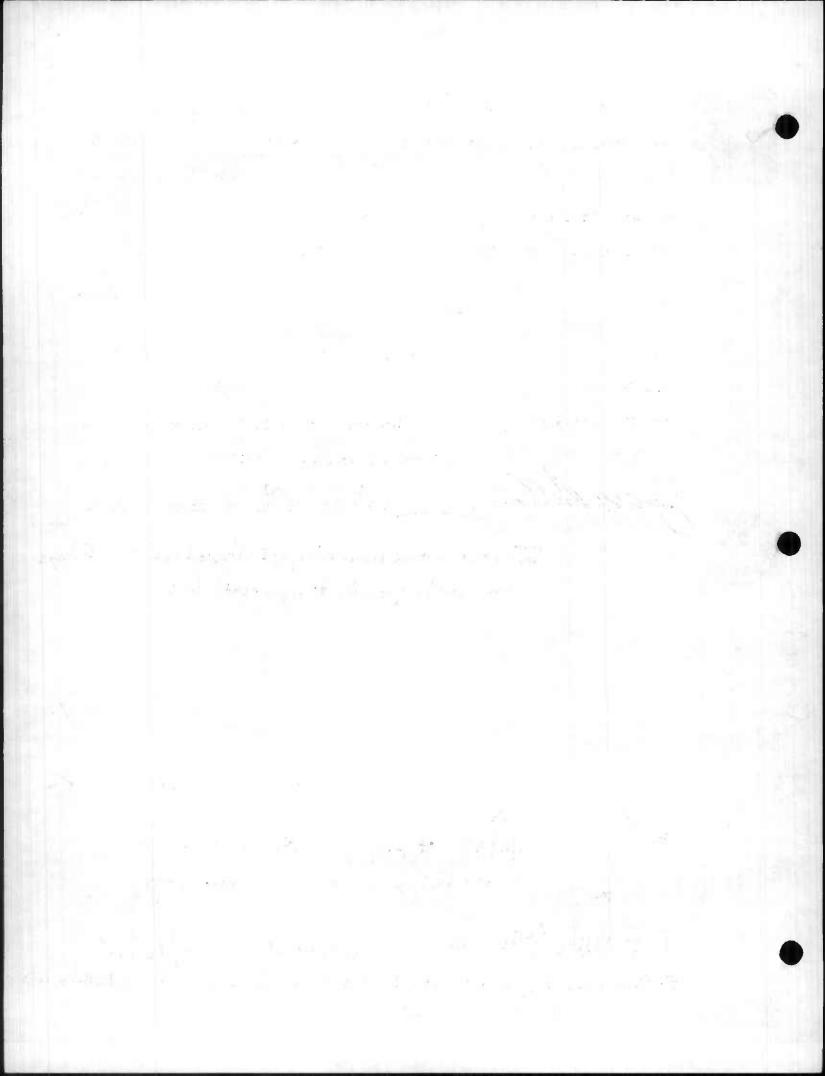
I Diractor: After to Certification: 5 Panding 1 Naturel 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) in by 4 - Homicida To the Hospital within 24 hours e 29a, Certifier 1 Certifying Physician: To the best of my knowledga, death occurred at tha time, date and piece, and due to the ceuse(s) end manner as stated.
2 Medical Exeminar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) Medical 29d. Data signed/(Month, Day, Year) 32. Registiar's Signature Panda 12 State

DHMH 16 Rev 6/95



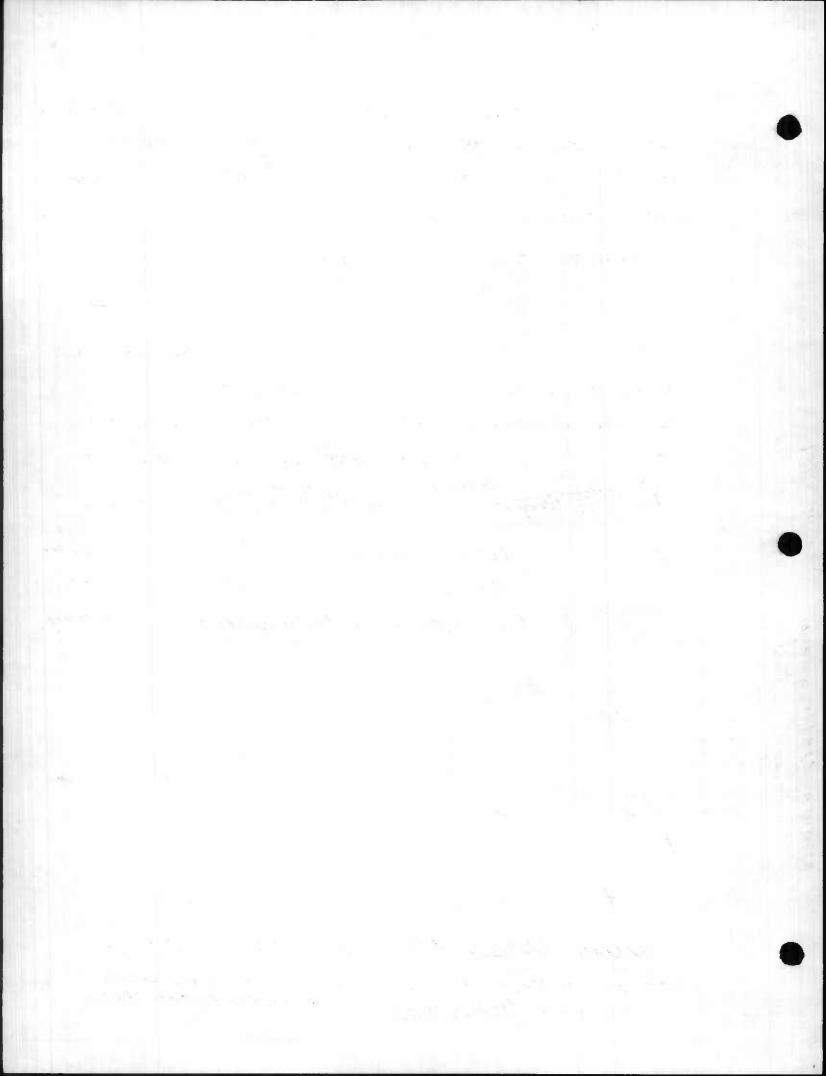
State of Maryland / Department of Health and Mental Hygiene Q Q

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uneral irector	5. Sociel Secur 213-03		Sex 7. 1⊠M 2□ F	Age (In yrs. la	st birthday) If Under Months	1 Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De 7/24/1	y, Year)	9. Birthplece (Ste Country) Maryland	ete or Foreigr
Mo III	10e. State	10b. County		10c. City,	Town or Location					10d. Insid	le City Limits
or thems 23e or 23e-f show uniner must be notified at / Funeral Director	Maryla	nd Wicom	ico		Salisbury					1 🔀	Yes 2□No
at be notified al Director	10e. Street and 229	Number Canal Park	Drive #2	205	10f. Zip	Code 218	04		10g. Citizen of US		
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		Nichols						Smith	-		
To		t's Name/Relationship			19b. Mailing Address						
	20e. Method of	llen Nicho	rs/Daugnt		I U 26 A Q a	ms S	t., Apt.	3D, Sa		, MD 2180 City or Town, Stel	
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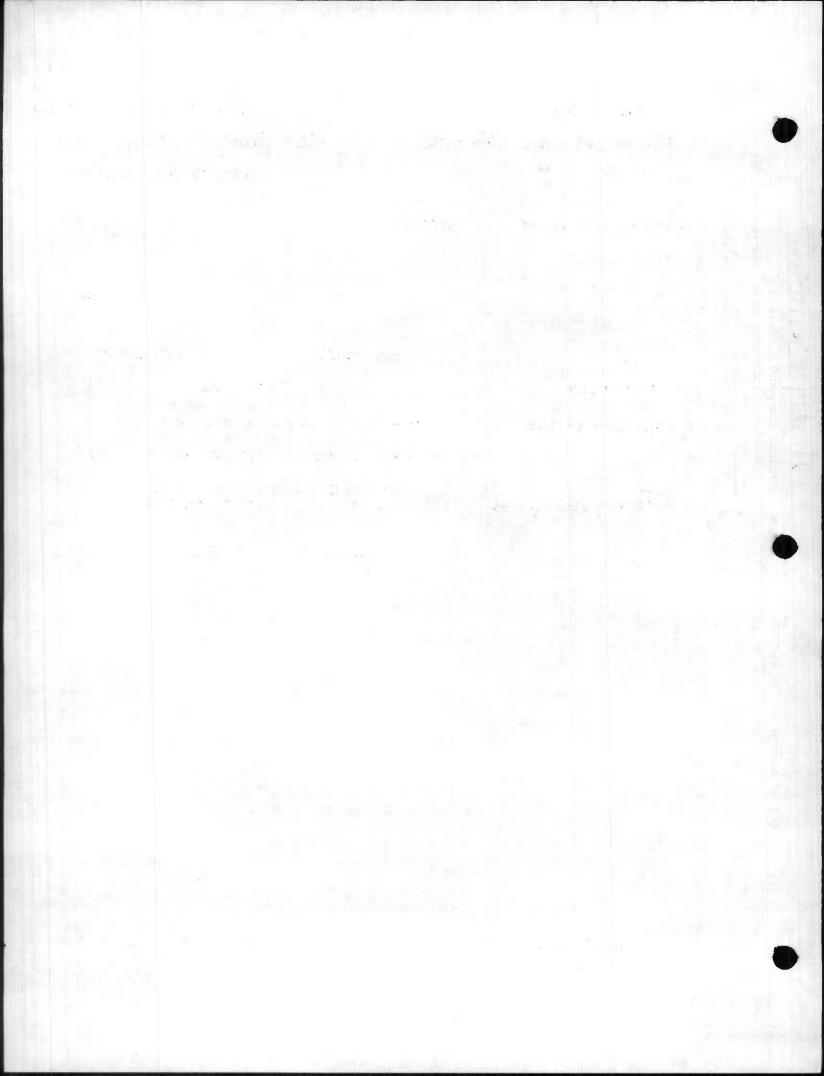
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/Med		NORMA ADK	INS	NC	TTINGHA	M	Januar	7	1998 07	121
Exami		4e. Fecility Neme (If not institution, give street and n	umber)			4b. City, Town, or L	ocation of Death	4c. County	of Deeth	
		PENINSULA REGIONAL ME	DICAL C	ENTER		SALISBU	RY	WIC	OMICO	
Funeral	i	Social Security Number 6. Sex		. last birthday)	If Under 1 Year Months Dev	ar If Under 24 Hrs.	8. Date of Birth (Month, Day,	Vocal	9. Birthplece (State Country)	e or Fore
Director		219–36–5881 1□ M 2対F Usuel Residence of Decedent	74	Yrs.	Months Dey	Hours Min.	4/24/23	3	Maryland	
land		10e. Stete 10b. County	10c. C	ity, Town or Lo	cation				10d. inside	City Lin
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r 28a	Director	10e. Street end Number			10f. Zip Code		1	0g. Citizen of \	Whet Country?	
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deatl	Funeral	11. Maritai Status 12. Was De	cedent Ever in U	U,S. 13. V		f Hispenic Orlgin? (Sp ben, Mexican, Puerto	ecify Yes or No-	-	e - Americen Indian	
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5-0020 72 hours after netural: or ite	by	3 ☑ Widowed 4 □ Divorced If Yes, G	ive Dates:	1	☐ Yes 2 🗷 No	o Specify:		Specify	White	
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other Hy	Be	17. Fether's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	Aaiden Suman	10)	
ld by ked ked	TO E	Wilmer ERnest Adkins				Myrtha	Brown	1		
Maryland rd 2 should be file ith and Mental Hy 77 is merked othe treumatic event,		19a. Informent's Neme/Relationship (Type, Print)		19b. Mailin	g Address (Stree	et and Number or Rui		, City or Town,	State, Zip Code)	
Mnd 2		John Richard Nottingha	m/Son	4039	Meadwo	Bridge Co	ourt, Sal	lisbury	, MD 2180	4
Baltimore, Maryland 21; permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: if Item 27 is marked other tha Important: ovent, if a nacked other tha 2000.		20e. Method of Disposition	20b.	Plece of Dispos	sition (Name of natory or other p	(con)	Dete	20c. Location -	City or Town, Stete	
Baltimore, semit. Pages 1 ar Separtment of Hea mportant: if Item 2 in y injury or other more.		1 ∑Burial 2 ☐ Cremetion 3 ☐ Removal from 4 ☐ Donetion 5 ☐ Other (Specify)	n State		Memoria		1/10/98	Salish	oury, MD	
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Depariment on the popular of the pop		M. TON	M0105			y Funeral	Home			
_		Novice #4. Wormson			501 Sno	w Hill Rd.	, Salish	oury, M	D 21804	
		23e. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	each line.	ith. Do not ente	er the mode or a	ying, such es cerdiec	or respiretory arre	est,	Approxin Intervel 8 Onset er	Between
Physician /Medicai	_	Immediate Cause (Final								
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tificate be any physician as the buria	edical	resulting In deeth) Lest	Due to (or as a consequ	uence of):					1
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death cert death cert e attandin od for usa	Physician/M								1	
. 0 0 0	ysic	Pert il. Other eignificent conditione contributing to	death but not res	sulting In the ur	derlying cause g	given In Part I.	23b. Did to	bacco use co	ntribute to the caus	e of de
that the de detached		CVA					1 🗆 Y	es 2 No	3 Probably 4	Unk
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OT VICAL Physician: T this cartificat ral director, p	2		Inpatient 2	ER/Outpetien	3□ DOA	other: 4□ Nursing Ho	ome 5 Reside	ence 6 🗆 Oth	er (Specify)	
	ü	27. Menner of Deeth 1 ♣Naturel 5 ☐ Pending (Mo	of Injury nth, Day Year)	28b. Time of Injury	28c. Inj	jury et /ork?	28d. Describe ho	w Injury occur	red	
DIVISION C at or Attending Pi after death. I Director: After the	Certification:	2 Accident investigation				☐ Yes 2☐ No				
Am ar de recto	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plea	e of Injury - At h	nome, farm, stre	et, factory, office	е	28f. Location (St City or Town		per or Rural Route N	umber,
	Cer		and the following	,,,				,,		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After complately filled in by the fune	edical	29a. Certifier (Check only 2 Medical Examiner: On the I	basis of exemina	owledge, death ation end/or inv	occurred at the	time, dete end plece,	end due to the ce	euse(s) and me ate end place,	enner es steted. end due to the ceus	e(s)
the l	Med	one) end mei	nner stated.							
5 3 5 9	-	29b. Signeture end title of certifier	. 0 11	110		nse number		9d. Date signe	d (Month, Day, Year)
		many Wi	y a	11/2	D	32017		1/7/	98	
		30. Name end eddress of person who completed cert	se of deeth (Ite	m 23e) (Type, I	Print)		,		100	
9		MATIEN MOENDEA	- MD	106	WII	FORD S	+ su	17 50	1412	
St	ate	30. Name and address of person who completed cau MAHELM MENNICH 31. Date filed (Month, Day, Year) JAN 14 1998	Registrer's Sign	nature		suis!	BURY	ms	21804,	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Marylar		icate of	Death	R	eg. No.	0281	1
Physician /Medical	Decedent's Name (First, Middle, Las JAMES E. OLNEY					Month MUURY tion of Deeth	Dey 17, 19	78 9:5	of Death
Examiner Funeral Director	5. Social Security Number 6. Se xi 212-36-7036	EZ HOSPIT.		Under 1 Yeer onths Deys	SIEN BUL If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Dey,	4c. County of A. A. Yeer) 1939	9. Birthplece (Stete Country) MARYLAND	or Foreign
ryland how Lat	Usual Residence of Decedent 10e. State 10b. County	10c. Ci	ity, Town or Locati	on				10d. Inside	
or 28a-f show be notified at Director	MARYLAND ANNE ARU 10e. Street end Number	NDEL EDG	EWATER	Of, Zip Code		11	0g. Citizen of W		es 2 No
020 us after doath v st, or thems 23s Examiner must by Furneral	235 MAYO ROAD 11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		2103 Decedent of H s, specify Cube Yes 21XNo	ispenic Origin? (Speci en, Mexican, Puerto Ri	fy Yes or No- cen, etc.)		- American Indien, k, White, etc.	
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Merital Hygiens at 1 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by I	15. Decedent's Edi (Specify only highest gred Elementery/Secondary (0-12) 10th	cation le completed) College (1-4or 5+)		's Usuel Occup d of work done NOT use retired	ation during most of working f)		W.T. R	siness/Industry	
and 2 be filed and other event, is	17. Father's Neme (First, Middle, Last)	0	CONO	11100110	18. Mother's Neme (First, Middle, M			
farylai 2 should b and Menta is marked surrette e	LOUIS OLNEY 19e. Informent's Neme/Relationship (7)	ype, Print)			end Number or Rurel I	Route Number		State, Zip Code)	
C 72 PM No.	LOUIS OLNEY (BROT 20e. Method of Disposition 1 ⊠ Burial 2 □ Cremetion 3 □ I	20b.	Piece of Disposition cometery, cremeter	on (Neme of any or other place	EDGEWATER,	Date	20c. Location -	City or Town, State	
Baltimore, pemil. Pages 1 a Department of the important: I llem any Injury or other other.	4 Donetion 5 Other (Specify, 21. Signeture of Funeral Service Licens			ame end Addre			P.A.	EK, HD.	
Physician /Medical Examiner	23a. Pert1. Enter the unease, or comp shock, or heert fillure. List only of limmediete Cause (Final disease or condition resulting in death)	ne ceuse on each line.	oth. Do not enter the	ne mode of dyir	er. ANNAPOL	h force	. 21401 sst, hi on	Approxim Intervel B Onset en	d Death
Box 68760, sath certificate be executed attending physician and for use as the buriel-transit clary/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	С	or es e consequen		53.				
the death certiful by the attending tached for use enthysician/Mc	Pert fl. Other significent conditions co	ntributing to death but not rea	sulting In the under	dying ceuse giv	en in Pert I.			tribute to the caus	
Division of Vital Records, P.O. Box within 24 hours of a transfer of the transfer of the Funcial or Attending Physician: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/M						24a. Wes e	n eutopsy ned?	24b. Were eutops evailable pric completion of of death?	or to
al Re licate ha						1□ Ye	/	1 ☐ Yes 2	No No
of Vit	25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No		ER/Outpetient	3 DOA Oth	4 LI Nursing nome	5 Reside	ence 8 Othe		
Division c the Hospital or Attending Pl thin 24 hours eiter deeth the Funeral Director: After th mpletely filled in by the tunera Medical Certification:	27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Date of Injury (Month, Dey Year)			Yes 2□No		ow injury occurr		
Divi	4 Homicide determined	28e. Plece of Injury - At h building, etc. (Speci	nome, farm, street, ify)	factory, office	28	City or Town	reet end Numbe n, Stete)	er or Rurel Route N	imper,
Divisio To the Hospital or Attendit within 24 hours electrodesth. To the Funeral Director: A completely filled in by the ta Medical Certificati		sician: To the best of my knowner: On the basis of examine end menner stated.							9(s)
To the vicinity of the comp	29b. Signature end title of certifier	2MD		29c. Licens	40521		Tonuar	(Month, Dey, Yeer, 17,199	
	30. Name end address of person who complete the complete state of	ompleted ceuse of deeth (Ite	m 23e) (Type, Prin	1) 3350 nove, r	no 212	Aveni	re Su	ite 302	
State Registrar	31. Dete filed (Month, Day, Yeer) JAN 2 0 1998	32. Registrar's Sign	eture fandell						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 8 0 2 8 | 8

					Cer	tificate of	Deam		Reg. No.		
Physici	an	1. Decedent's Name (First, Middle, I						2. Date of De		, 1998	3. Time of Deat
/Medic	cal	Ruth Eleanor Pe		al .			4h City Tourn	Janua or Location of Deatl			1:06 A
Examir	ner	Holy Cross Hos		"			Silver	Spring		Montgo	mery
Funeral Director		212-74-4824	Sex 7. A 1□ M 2√2 F	nge (In yrs. last 95	birthday) Yrs.	If Under 1 Yea Months Days		in. 8. Date of Bir (Month, Da Decemb	th y, Year) er 2,	9. Birthp Coun	lace (State or For tny) Wiscons
show		Usual Residence of Decedent 10a. State 10b. County		10c. City, To						1	0d. Inside City Lin
Sa-f sh Offined	ector		gomery		Silve	er Sprin	g				1 ☐ Yes 2 🛣
23a or 2	Funeral Director	11700 Old Colum	nbia Pike			10f. Zip Code 20	904			n of What Coun ed State	
"natural", or items 23a or 28a-f shov odical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Test 2 Test 1 Test 2 Test 1 Test 2 Test 1 Test 2	? M No		Vas Decedent of Yes, specify Cu		(Specify Yes or No erto Rican, etc.)		Raca - Americ Black, White, pecify:	
	Completed	15. Decedent's (Specify only highest g	Education rade completed)	10	6a. Deced	ent's Usual Occi	upation e during most of v ed)	vorking	16b. Klnd	of Business/Inc	dustry
than	omp	Elementary/Secondary (0-12)	College (1-40	r 5+)		usewife	ea)		h	ousewif	e
n and Menial Hygiene. Is marked other than Irsumatic event, the M	To Be C	17. Father's Name (First, Middle, La: Charles Diener	ot)					lame (First, Middle,	Malden Su	ımame)	
r neath and Mer tem 27 is marke other trsumatic		19a. Informant's Name/Relationship Marilyn Peterse						Rural Route Numb			
V 0 €		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special		ceme	etery, cren	sition (Name of natory or other pi	,	Date 1/27/98		tion - City or To	
important: any injury once.		21. Signature of Funeral Service Lic	0 / /	101	-	Name and Add		2,2.,,,			,
ysician ledical aminer		fant : Enter the disease, or co hock, or heart failure. List on fant failure is a condition resulting in death)			Do not ente	er the mode of dy				Spring	Approximate Interval Between Onset and Death
physician and s the burial-transit	the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. ————————————————————————————————————	Due to (or as							
0.8		resulting in death) Last	l d								
ittending for use a		resulting in death) Last Part ff. Other significant conditions		but not resulting	g in the ur	derlying cause g	iven in Part I.	23b. Did	tobacco us	a contribute to	the cause of dea
ittending for use a	Physician/I	resulting in death) Last	contributing to death				М		tobacco us		the cause of dea
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ate hes been signed by the ettending page 2 should be detached for use a	Completed by Physician/	Part ff. Other significant conditions	contributing to death				М	1 □	Yes 2 an autopsy	No 3 Prot	ore autopsy finding allable prior to mpletion of cause
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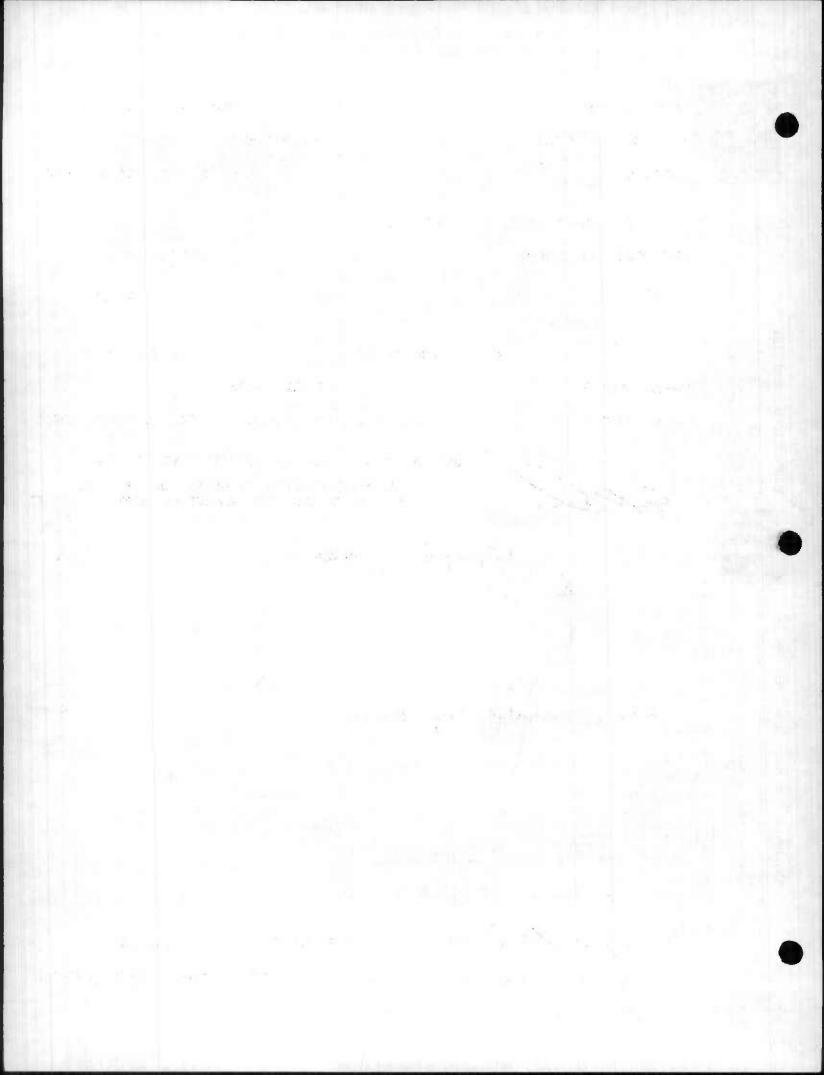
State of Maryland / Department of Health and Mental Hygiene

		A December 1 March 1 M	At the tra			Ce	rtifica	te of	Death			eg. No.	J	128	19
Physici	an	Decedent's Neme (First, and Company)	moule, Las								Dete of Deet Month	Dey	Yeer		of Death
/Medic		Alfreda		Pitt							anuary	1			30 PM
Examir	er	4e. Fecility Neme (If not inst	tution, give	e street end numb	per)				4b. City, Town, or	r Location	on of Deeth	4c. County	of Deeth		
		Manor Care							Silver	Spr	ing	Mont	gome	ry	
Funeral Director		5. Social Security Number 578-46-0242 Usuel Residence of Decede			. Age (In yrs. 99	last birthdey) Yrs.	If Unde Months	Deys	If Under 24 Hr Hours Mir	n. 8. I	Date of Birth Month, Dey, V. 23	Year) 1899	9. Birth Cou Wisc	place (Stentry) onsir	te o <i>r Forei</i> g 1
ryland		10e. Stete 10b. Co			10c. Ci	ty, Town or Lo	ocation								City Limit
a Ma	cto	MD Mc	ntgo	mery	Si	lver S	pring	g						1 X □ Y	es 2 N
th th	lie	10e. Street end Number					10f. Zi	p Code			1	0g. Citizen of	Whet Cou	ntry?	
13a d	al	8505 Springva	le Ro	oad			20	0910			U	nited	State	2.5	
permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, i'm Med cal Exarting must be incitified and once.	by Funeral Director	11. Maritel Status 1 □ Never Married 2 □ 3 ☒ Widowed 4 □ Divo		12. Wes Deced Armed Forc 1 Yes 2 If Yes, Give Yeer or Det	△ No			-	dispento Origin? (en, Mexican, Pue Specify:	Specify erto Rica	Yes or No- in, etc.)		ck, White,	can Indian etc. Black	
2 should be filed within 72 hc and Mantal Hygiena. Is marked other then 'netur 'aumatic event, I'm Med cal	Completed by	15. Dec (Specify only h Elementery/Secondery (0- 12th	1	lucation de completed) College (1-4	for 5+)				pation during most of we d) e Assist			16b. Kind of B		ndustry	
filed with Hygiena. rther then		17. Father's Name (First, Min	idla i set)			AdillIII	ISLI	aLIV.	18. Mother's Ne		ret Middle I	YM			
Mantal Marked of	Be	Blake Ca							1 TO 1 TO 1 TO 1				ne)		
should and Man and Man amarke	To								L		Harre				
and 2 sho a a lith and n 27 is me		19a. Informent's Name/Rela Anna W. Pitt	S	faughter in law)	3900	18th	St.				n, D.C		20018	
permit. Pagas 1 and 2 Department of Haaith s Important: If Itam 27 is any Injury or other tra ance.		20a. Method of Disposition 1 (XBurial 2 Creme 4 Donation 5 Oth			ate	Plece of Dispo cemetery, crea coln M			ce) Cemetery		1/48	uitlan			
pemit. Departrimporta any inje		21. Signeture of Funeral Ser	vica Lican	me a	4212				ess of FecilityMc						
rificata be axecuted ng physician and tas the bunal-transit	Medical Examiner	disease or condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last	{	b. Cor	onary Due to (Artery or es e consec	Dise	ease	, Age						
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tha the	sic	Pert II. Other significent cor	ditione co	ontributing to deet	th but not res	sulting in the u	nderlying	cause giv	ven in Pert I.		23b. Did to	bacco use co	ntribute t	o the caus	e of deat
is that the de gned by the oa deteched	by Ph										1 🗆 Y	s 2⊠ No	3 ☐ Pro	bably 4	Unkno
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The lata he paga	ő										1 □ Ye	s 2 No	11	☐ Yes 2	!□ No
ilcian: Th cartificata rector, pag	Be	25. Wes case referred to me	dical						26. Place of De	eath (Cl	neck only on	Θ)			
dis X	To	exa <i>m</i> iner? 1 ☐ Yes 2 ☐ No		Hospital:	atient 2	ER/Outpatier	nt 3 De	OA Oth	100			nca 6 □Oth	ner (Speci	(y)	
Attanding Ph ir death. ector: Aftar thi by the funeral		27. Menner of Deeth 1 Neturel 5 Per 2 Accident	ending vestigation		Injury Dey Year)	28b. Time of Injury	f M	28c. Injui Woi 1 □				w Injury occur			
To the Hospital or Attanding P within 24 hours aftar death. To the Funeral Director: Aftar t complataly filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide	ould not be termined	28e. Pieca of	Injury - At h , etc. (Special	ome, farm, str fy)	eet, factor	y, offica		28f.	Location (St City or Town	reet end Numl n, Stete)	ber or Run	e <i>l Ro</i> ute N	umber,
ne Hospit n 24 hour ne Funera stataly fills	edicai	29a. Certifier 1 ★ Certifier (Check only one)	Ifying Phy ical Exam	yelcien: To the besi	s of exemine	owledge, deeth etion end/or in	occurred vestigation	et the tir	me, dete end pled opinion, death occ	ce, end courred a	due to the ce t the time, de	euse(s) end ma ate end pleca,	enner es s and due t	steted. o the caus	e(s)
omp	M	29b. Signeture and the of	HATEL TO	100	1.		29	c. Licens	se number		2	9d. Date signe	d (Month,	Dey, Year	7)
3		100	100	ay	m			0500	70		J	anuary	15,	1998	
		30. Name end eddress of pe Vincent Sutl	iff,	6504 Kei	nilwor	th Ave		Suite	200, R	iver	dale,	Maryla	and	20737	7
Sta Registr		31. Date filed (Month, Day,)	1998	33 Reg	Savids	eture 									

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_	- 1	Decedent's Neme (First, Middle, Las	t)		Certificate of	of Death	2. Dete of De	Reg. No.	, 0	3. Time of Death
Physic	ian						Month	Dey	Yeer	
/Medi		IRVING M. POSNER	atomat and area to a			4. Ch. Tour	JANUARY			11:15 PM
Exami	ner	4a. Fecility Neme (If not institution, give					or Location of Deat	,		
		HOLY CROSS HOSPITA			M. Indeed Vo	SILVER S		MONTGO		
Funeral Director		5. Social Security Number 6. Security Number 092-05-0393	XM 2□ F	80	thday) If Under 1 Ye Months De		n. 8. Defe of Bir (Month, De JAN 23	th by, Yeer) • 1917	9. Birthpla Counti VEW YO	nce (State or Foreign ORK
anyland	-	10a. State 10b. County		10c. City, Tow	n or Location				10	d. Inside City Limits
Be-f	Director	MARYLAND MONTGOME	RY	BETH	ESDA					1X Yes 2 No
₽ P P	D I	10e. Street end Number			10f. Zip Cod	е		10g. Citizen of V	Vhet Count	y?
23a		7420 WEST LAKE TER	RACE		20817			UNITED S	STATES	S
72 hours effer death with the Maryland "natural", or frams 28a or 28a-f show diest Eraninet mast be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates: 1	lo	13. Was Decedent of Yes, specify C		(Specify Yes or No arto Ricen, etc.)		e - Americe k, White, e : WHIT	tc.
within ena. then	Completed	15. Decedent's Ed (Specify only highest gred Elementery/Secondery (0-12)	de completed) College (1-4or 5-	+)	Decedent's Usuel Oc (Give kind of work do life. DO NOT use re	ne during most of w	rorking	16b. Kind of Bu		
9 0 = .		17. Fether's Name (First, Middle, Last)	4	ACC	COUNTANT	18 Mother's N	ame (First, Middle	U.S. GO		ENI
ed la b	To Be	DAVID POSNER				TILLIE	WARSHOFS	ΧY		
d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Reletionship (T			. Malling Address (Str					
f Health fam 27			wife		20 WEST L		CE, BETHI	ESDA, MA	RYLAN	D 20816
S 7 3		20e. Method of Disposition 1		JUDEAN	Disposition (Name of y, cremetory or other MEMORIAL	plece)	Dete 1/22/98	OLNEY		
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service 13	60	COBLI	22. Name end Ad DANZANSK	dress of Fecility	G MEMORIA	AL CHAPE	LS, I	NC.
		"Collaboration of the Collaboration of the Collabor				KVILLE PI				
Physician /Medical		23a. Pan 1: Enter the disease, or comp shock, or heart failure. List only o	- 1	1			ac or respiretory e	rrest,		Approximete Intervel Between Onset end Deeth
Examiner	er	disease or condition resulting in deeth)	Esop	Due to (or as e	CANC	125				· yrs.
ificate be axecuted g physician and as the bunal-transit	Examiner	Sequentially list conditions, if ony, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury	b	Due to (or es e	consequence of):				I	
icate be physicia s the bur	edicai	Ceuse (Disease or Injury thef initieted events resulfing in deeth) Lesf	C	Oue fo (or es e o	onsequence of):					
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death e atte	sicie	Pert II. Other eignificent conditione co	ntributing to death bu	t nof resulting Ir	the underlying ceuse	given In Pert I.	23b. Did	tobacco use cor	tribute to	the cause of death?
signed by the	by Physician/M		structive					Yes 2□No		ably 4 ☑ Unknow
been shoul	Completed b			4			24e. Wes	en eutopsy rmed?	com	e eutopsy findings leble prior to pletion of ceuse seth?
The ate h							1 🗆 '	Yes 2 No		Yes 2□ No
ysician: The scartificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				eeth (Check only o	one)		
Physician: this cartific ral director,	2	TILITIES 254340	Hospitel: 1 Kinpatien		tpetient 3L DOA		Home 5□ Resi			
Attending P or death.	ation:	27. Menner of Deeth 1 Maturel 2 Accident 5 Pending Investigation	28e. Dete of Injun (Month, Day			njuryet Nork? □Yes 2□No	28d. Describe	now Injury occurr	ed	
2 4 5 6	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Inju- building, etc.	ry - At home, fe . (Specify)	rm, streef, factory, offi	ce	28f. Locetion (City or To	Street end Numb vn, Stete)	er or Rural	Route Number,
he Hospital of 24 hours a he Funeral Dipletaly filled	edicai			examinetion en	, death occurred et fhe d/or investigation, in m					
within 2 To the	¥	29b. Signeture end title of certifier	00			ense number		29d. Date signed	_	ey, Year)
6		V ch	ace	M		35162		1/21/		
			S COM NOUTS		Type, Print)	Lock	wood or	IVE S	ilve spo	obozou C
Sta	te	31. Date filed (Month, Dey, Year)	32 Registra	r's Signature	and a Poly					



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the found retained by the intending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

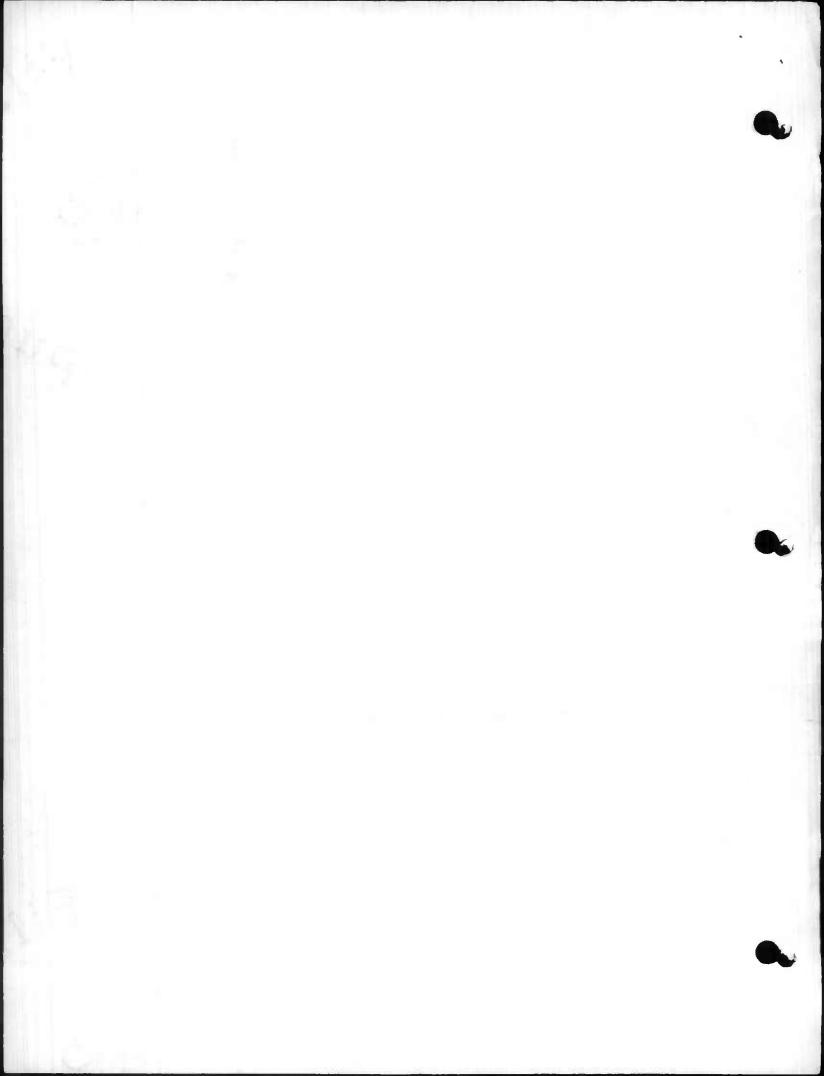
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

ME OF DEATH
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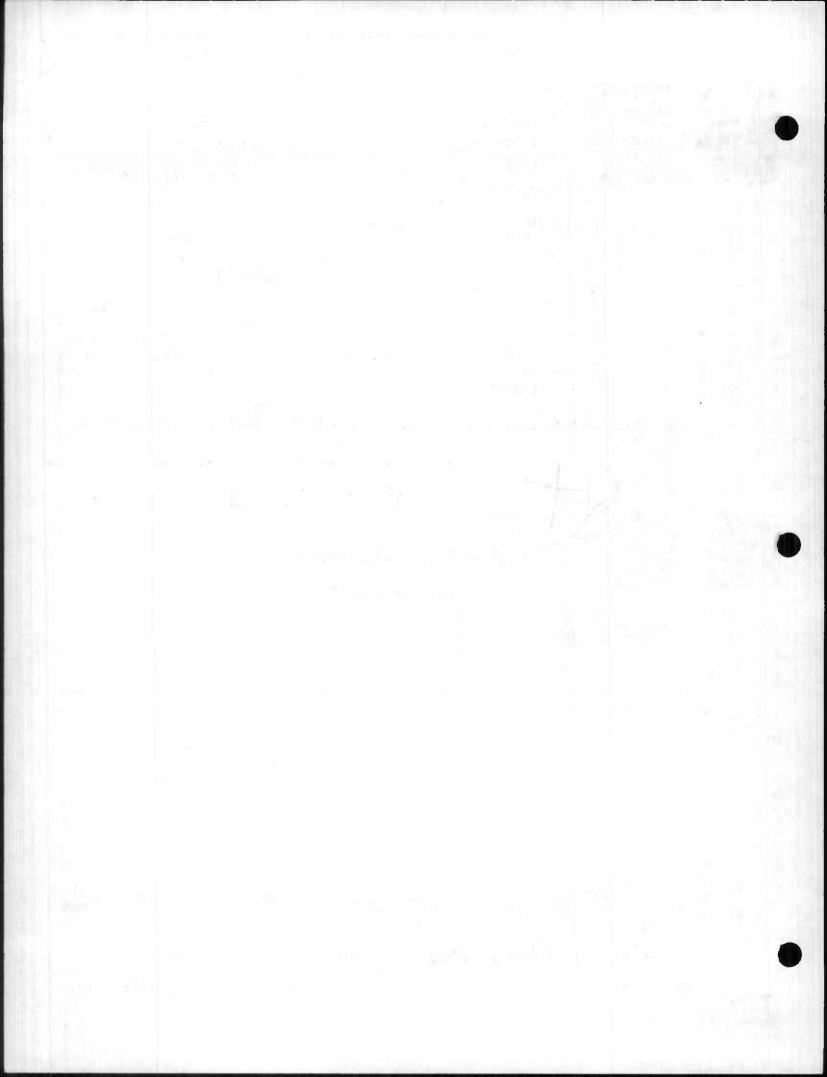


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 16,1898 **Physician** Month Betty Polaski

4a. Fecility Nema (If not institution, give streat and number) /Medical 4b. City, Town, or Location of Daath 4c. County of Daath Examiner 100th Pr en P OSPITE Arunde indel ナイクマル Year If Under 24 Hrs. Neys Hours Min. 5. Sociel Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💯 F **Director** 212-48-2362 52 MARYLAND JAN. 18, 1945 Usual Rasidenca of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or leans 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 No Director MARYLAND ANNE ARUNDEL PASADENA 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1816 CREMEN ROAD 21122 U.S.A. Funera 12. Was Dacedant Ever in U,S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Maritel Status 14. Rece - Amarican indien, Black, Whita, atc. 1 ☐ Yes 2 XNo If Yas, Giva 1 ☐ Nevar Married 2X Marriad 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Detes: Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry al Hygiene. ANNE ARUNDEL PUBLIC Elementary/Secondary (0-12) College (1-4or 5+) 10 CUSTODIAN SCHOOL SYSTEM 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be 2 should be and Mental CLIFTON ALTON THOMPSON MAGGIE 2 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) Important: If item 27 is any injury or other train Pages 1 and name name of Health PAUL DAVID POLASKI (HUSBAND) 1816 CREMEN ROAD, PASADENA, MARYLAND 21122 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovel from Stata MEADOWRIDGE MEMORIAL PARK 1/20/98 ELKRIDGE, MARYLAND 4 Donetion 5 Other (Specify) eral Service Ligensee 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 or complications that caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrest, at only one cause on each line. Approximata fntarval Batween Onset end Death Physician immediate Causa (Final disaase or condition rasulting in death) /Medical **Examiner** Dua to (or as a consequence of) Examiner urdiac arres certificate be axecuted physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceusa (Disease or injury that initiated events Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) rasulting in deeth) Last 68 usa for PO datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Division of Vital Records. by 24b. Wara autopsy findings available prior to complation of cause of deeth? 24a. Was an autopsy Completed peen pege 2 has 1□ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical axaminar? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 ☐ Yas 2 No 10 funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 Panding invastigation death. 1 ☐ Yas 2 ☐ No 2 Accident after death Director: / 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 3 4 Homleida To the Hospital o within 24 hours af To the Funeral Di completely filled is 29a. Certifiar 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura end title of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 1/16/98 D44377 mes 30. Nama and address of parson who complated cause of death (Itam 23a) (Type, Print) 6320 Ritchie Highway, Suitel Glen Burnie, MD 21061 Pieri, mo Deneen 31. Data filed (Month, Dey, Year)
JAN 2 0 1998 32. Registrer's Signetura

Suha Davidson Randall State

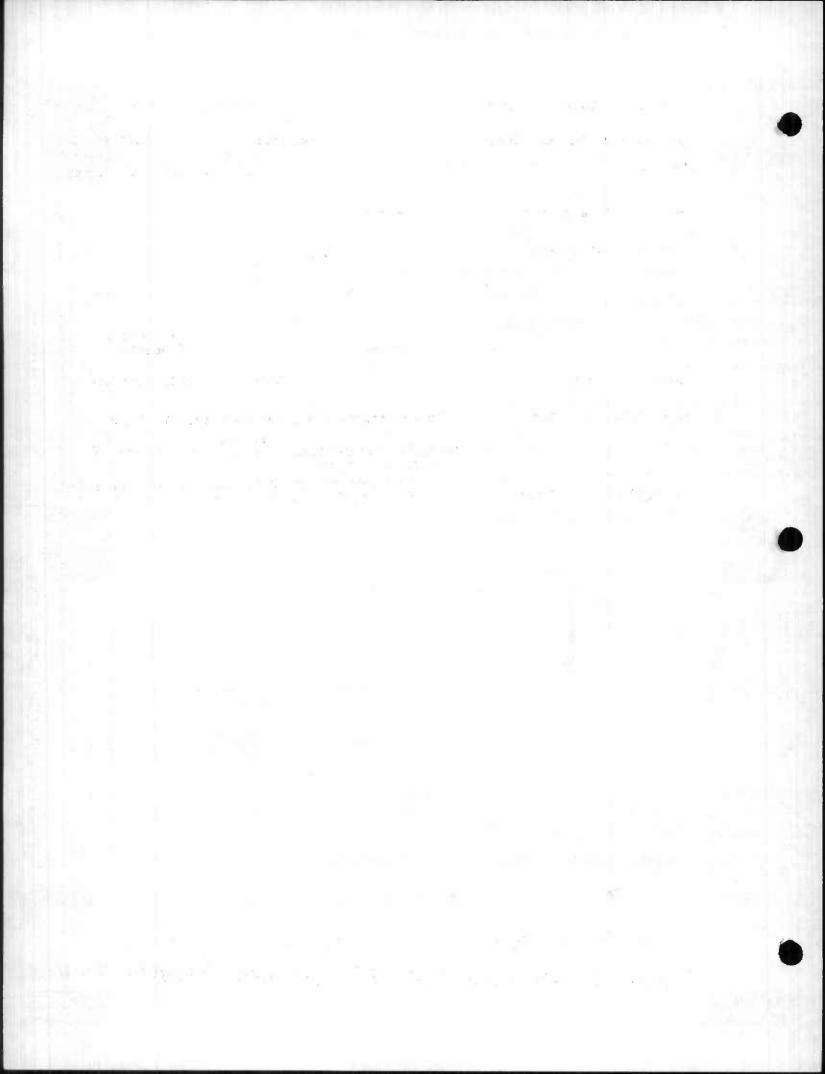


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Donna 8:41 pm Louise Petry 12, January 1998 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 3, 191 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1□ M 2□ F 81. 476-05-1235 Yrs. Director 1916 Minnesota Usual Rasidanca of Decadant 10a Stata 10h County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at MD Anne Arundel Arnold 1 Yas 2/3/No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6 1480 Grandview Road "naturel", or items 23a 21012 USA Funeral death 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑No If Yas, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Pages 1 and 2 should be filed within 72 hours efter 1 ☐ Navar Married 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ② No Specify: Specify: White P 3 X Widowed 4 ☐ Divorced Completed 16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. Elementary Elamantary/Secondary (0-12) Collega (1-4or 5+) Teacher Education Department of Haalth and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, If once. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Otto Caroline Maude Johnson Lundblad 2 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Susan Petry/daughter 36 Kensington Road, Garden City, NY 20b. Place of Disposition (Nama of cematary, crematory or other place)
Jerusalem Evangelical 20c. Location - City or Town, Stata 20a. Mathod of Disposition Jan 15 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 1998 Lutheran Church Cem. 22. Nama and Addrass of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Gov. Ritchie Hwy., Severna Park, MD 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immadiate Causa (Final myocaudial infauction 30 minuter disaasa or condition rasulting in death) Examiner Due to (or as a consequance of): covardy artery disease SYVS. Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiata cause. Enter Undarlying Causa (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consequanca of): ettending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to complation of causa of death? been si 24a. Was an autopsy performed? Be Completed s certificata has t director, page 2 s 2 100 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: director, 25. Was casa rafarred to medical 26. Placa of Daath (Check only ona) examinar? examinari 1 ☐ Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Day Year) Certification: 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accidant 5 Panding eftar deeth.

Director: Aft
d in by the fur 1 ☐ Yas 2 ☐ No invastigation 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida within 24 hours eftar To the Funeral Dire completely filled in b 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated. 29a. Certifiar Medical (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licansa number Bestgate Annapolis, u.d. 21401 30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print) Selonich UniO 31. Data filed (Month, Day, Year)

JAN 2 0 1998 32. Bagistrar's Signatura State ria Davidson Registrar



State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Dete of Deeth 3. Time of Death

Funeral Director

the Meryland 10a State 10h County 10c. City. Town or Location Frammer must be notified at Directo Maryland St. Mary's California 10e. Street and Number 10f. Zip Code with 23535 Gross Court 20619 death v Funeral 12. Wes Decedent Ever in U,S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or item eny injury or other traumatic event, the Medical Estimate. 1 ■ Yes 2 □ No
If Yes, Give
Year or Detes: 1944-1946 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: þ 3 Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Analyst 17. Fether's Neme (First, Middle, Last) Roy Green Phillippi 19e. Informant's Neme/Relationship (Type, Print) Doris Marie Phillippi, Wife 20b. Pleca of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremetion 3 □ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Blankenshi **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) PNEUMONIA /Medical Examiner Due to (or es e consequence of): Examiner ALZHRIMBAIS physician and the burial-transit the death certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): as for usa as signed by the a d be datached f ARTRRY CURONARY DISBASB à Completed is certificete hes director, page 2 Physicien: Be 25. Wes case reterred to medicel exeminer? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 2 this 28e. Dete of Injury (Month, Dey Year) funerel 27. Menner of Deeth 28b. Time of 28c. Injury at Work? Certification: Aftar 1 Naturel 2 Accident 5 Pending investigation or Attending s effer des. 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) in 24 hours etter dhe Funeral Direct Indicate in branch in betaly filled in branch in 4 Homicide 29a. Certifier Ecrifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) and menner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and menner stated. To the To the Comple 295. Signature and title of certifier 29c. License number D19052

1. Decedent's Neme (First, Middle, Last) Month January 14, 1998 7:20 PM John Warren Phillippi 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not Institution, give street end number) St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplece (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 1■M 2□F Yrs. Virginia 224-24-8993 72 August 17, 1925 Usuel Residence of Decedent 10d. Inside City Limits 1 ☐ Yes 2 ■ No 10g. Citizen of Whet Country? United States 14. Reca - American Indien. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Defense Contractor 18. Mother's Neme (First, Middle, Meiden Sumeme) Beulah Blair 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23535 Gross Court, California, Maryland 20619 20c. Location - City or Town, Stete Charles Memorial Gardens 1/17/98 Leonardtown, Maryland 22. Name end Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that called the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each Approximate Interval Between Onset end Deeth DISZISR Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en autopsy parformed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

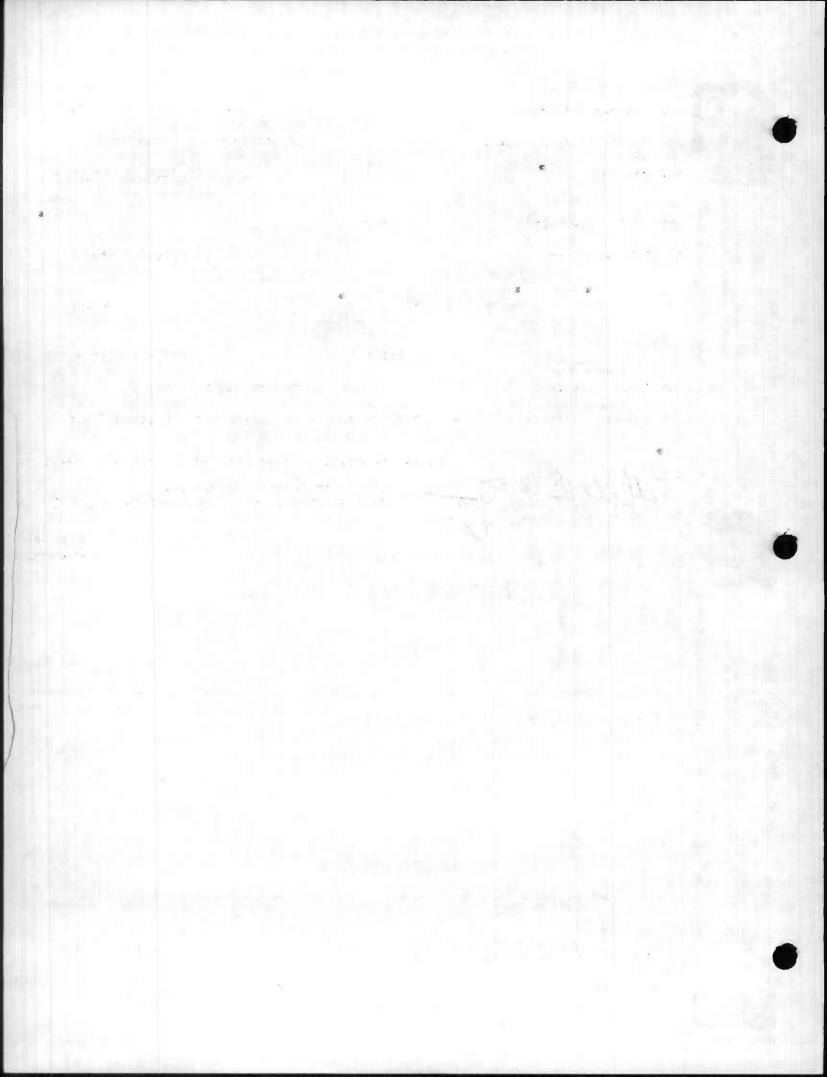
29d. Date signed (Month, Day, Year)

Dennett MD

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

John L. Bennett, M.D. 31. Date filed (Month, Day, Year) JAN 16

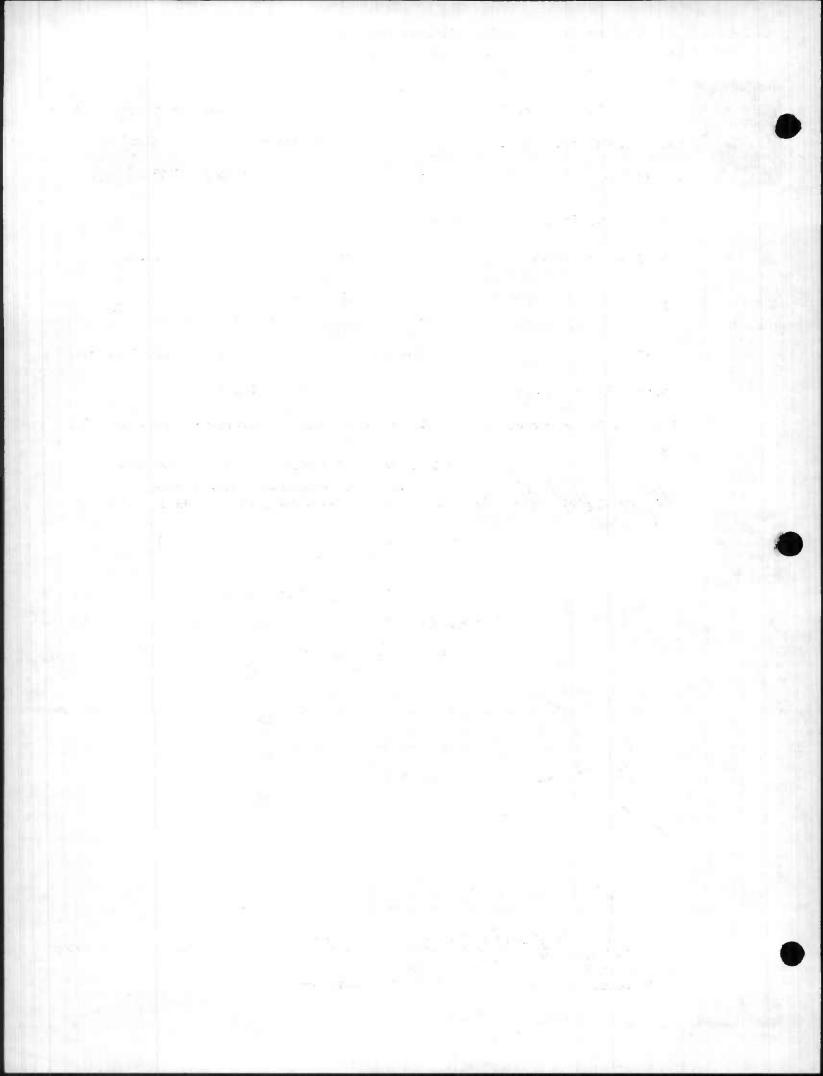
California, Maryland 20619 32. Registrars Signature Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medi Exami		4a. Facility Name (I		ive street end number			4b. City, Town, or L		4c. County of	110
		Fallston	General	Hospital			Fallston		Наз	rford
Funeral Director		5. Social Security N	355	Sex 7. A 1 M 2 ▼ F	nge (In yrs. lest birt) 88 ^Y	Months Dave		8. Date of Birth (Month, Day January	Year) 19,1909	9. Birthpiace (State or Foreig Country) Maryland
/land		Usual Residence of 10a. Stata	10b. County		10c. City, Town	or Location				10d. Inside City Limit
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or 28	Direc	10e. Street and Nur	mber			10f. Zip Code		1	0g. Citizen of Wh	nat Country?
ath w	100		lewood I			2101			U.S.A	١.
020 urs after el', or its	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed	ied 2 Married	12. Was Deceder Armed Forces 1 Yes 2 tf Yes, Give Year or Dates	? [No	13. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☒ No		pecify Yes or No- Rican, etc.)		- American Indian, White, etc. White
21215-0020 d within 72 hours at giena. r than "naturel", or the Medical Exam	Completed	(Spec	15. Dacedent's I	Education rede completed)	16a. I	Decedent's Usuai Occu	pation a during most of work	cina	16b. Kind of Bus	
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Maryland 212. d 2 should be filed within the and Mental Hygiena. 7 is marked other than traumatic event, the M	To Be		Larry H				Maria			
re, Maryla s 1 and 2 should f Health and Men tem 27 is marke other traumatic	-	19a. Informant's Na			19b.	Mailing Address (Stree			, City or Town, S	tate, Zip Code)
Z Signal		Thomas L	. Pogue	Grandson		l Deerhill		Abingdon	, Maryla	and 21009
Baltimore, semil. Pages 1 a separament of Her mportant: if item inty injury or othe ance.		20a. Method of Disp		☐Removal from State	20b. Place of cemetery	Disposition (Name of , cremetory or othar pla	aca)	Date	20c. Location - C	ity or Town, State
time Page		4 Donation	5 Other (Space	ify)		ts Episcopal		1/21/98	Avenue, Ma	aryland
Bal Bal Bal Bal Bal Bal Bal Bal Bal Bal		21. Signature of Fu	neral Service Lice	insee /	1 -	22. Name and Addr Mattingley	ess of Facility y-Gardiner	Funera	l Home,	P.A.
- 40244		Much	racht	Hard	mer	P.O. Box 2	270, Leona	rdtown,	Marylan	d 20650
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of Vital Rec hysician: The law his certificate has b I director, page 2 s	Completed	10	efle	x Eso,	plagi	NJ /		1 □ Ye	es 20XNo	of daath? 1 ☐ Yes 2 ☐ No
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Division or Attending I after death. Director: After d in by the funer	Certification:	27. Manner of Deati 1 Natural 2 Accident	5 Pending investigation		ey Yeer) 28b. Ti	ury Wo	ork? Yes 2 No	280. Describe no	ow Injury occurred	
DIVIS	ertific	3 Suicide 4 Homicida	6 Could not datarmine	286. Placa of II	njury - At home, fari tc. <i>(Specify)</i>	m, street, factory, offica		28f. Location (SI City or Town	reet end Number n, Stete)	or Rural Route Number,
Division o To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director. Aftar thi completaly filled in by the funeral	edical C	29a. Cartifiar (Check only one)	1 Cartifying P 2 Medical Exa	hyalclan: To the best minar: On the basis and manner s	of examination and	daath occurred at tha ti for Investigation, in my	ima, data and placa, opinion, daath occur	and dua to tha cred at the time, d	ausa(s) and mana ata and place, an	nar as stated. d dua to tha cause(s)
To th To th comp	Me	29b. Signature and	titimot centify	V 1/	0		se number	2	9d. Date signed	(Month, Dey, Year)
		• /	Into	141. Va	laca	DI	6389		James	4 18,1998
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		Prefe 31. Date filed (Mont		arao, MD		lston, Mary	yland 2104	+7		
Sta Registi					trar's Signature Provident Rom	dall				

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month JAMES PENDLETON 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 1 XM 2□ F Deys 224-44-5191 64 Yrs. Usual Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. WORCESTER BERLIN 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 DOCKSIDE DR. 21811 USA 12. Wes Decadent Ever in U,S. Armed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Detes: KOREA Raca - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specity: Specify: WHITE 3 Widowed 4 Divorcad 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) SECURITY HEALTH CARE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) JOHN PENDLETON CLARA PUGH 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JULIE PENDLETON DOCKSIDE DR. BERLIN, MD., 21811 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Locetion - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) SUNSET MEMORIAL PARK 1-19 BERLIN, MD. 21. Signature of Fundal Service Licanses 22. Name end Address of Facility ULLRICH FUNERAL HOME BERLIN, Mp., 21811 23a Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Final VENTRICULAR FIBRILLATION disease or condition resulting in death) MINUTES Due to (or es e consequenca of): ANTERY DISEASE YRI CORONARY Due to (or es e consequence of): AS OV D Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner Examiner

ettending physician and for use as the buriel-transit

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certificete

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certification completely filled in by the funeral director,

Physician/Medical

by

Completed

Be

2

Certification:

Medical

P.O. Box 68760

Records,

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director.

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at

Department of Health end Nantal Hygiene. Important If Item 27 is marked other than eny injury or other traumation.

3

James Him.

Pendleton 1 224-44

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest

art II. Other aignificant condi	itions contributing to	death but not resul	ting In the underlying	cause given in Pe

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 Natural 2 Accident 5 Pending investigation

1 ☐ Inpatient 2 ★ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

29a. Certifier

3 Suicide

4 Homicide

12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Dey, Yeer)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

6 Could not be determined

0912

State Registrar 403 QUINCY ST. SALISBURY, MD., 21801
31. Date filed (Month, Day, Year)
32. Registrer's Signeture JAN 1 6 1998

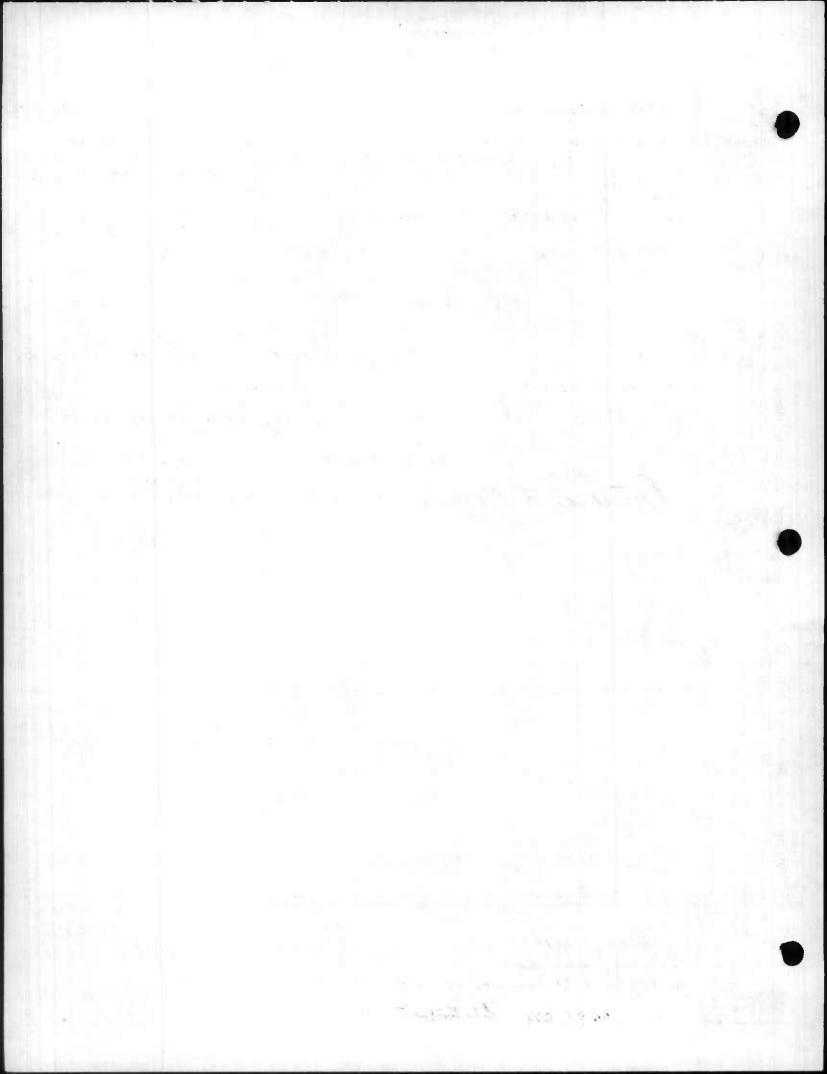
This Davidson Bondage

D.J. CHODNICKI, MD

WA!

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3 Time of Death **Physician** 18 -William Homer Pruitt 1 98 4:36 P.M. /Medicat 4a. Facility Name (If not institution, giva streat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 210 Ironshire Street Snow Hill Worcester if Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) If Under 1 Year 5. Social Sacurity Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days XOM 2DF Months Yrs. Director 69 218-12-1335 8-30-28 Stockton, Md Usuai Residenca of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at Director Md. Worcester Snow Hill Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 Ironshire 21863 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. hours after 1 ☐ Never Married 2 ☑ Married N Yes 2 No fi Yas, Give Year or Dates: 1952-56 0 altimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white 'natural', Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) 15. Dacedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Agriculture -Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Depertment of Health and Mental Hygien. Important: if item 27 is marked other that any Injury or other traumette. 12 Plant Supervisor Wor. Fertilizer Co. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First Middle Malden Sumama) Be Herbert O. Pruitt Mildred Smack 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Peggy Pruitt (wife) 210 Ironshire St., Snow Hill, Md. 21863 20b. Place of Disposition (Nama of 20a. Method of Disposition Date 20c. Location - City or Town, State cematary, crematory or other placa) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Whatcoat Cemetery 1/21 Snow Hill, Md. 21. Signatur V Funeral Servica Licensee 22. Name and Address of Facility P.O. Box 87 Dennis Funeral Home, Snow Hill, Md. 21863 dennis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medicai LUNG CANCER MONTH Examiner Due to (or as a consequança of). certificate be axecuted physician end s the bunal-fran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) 88 P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate of Vital Be 25. Was case referred to medical 26. Place of Death (Chack only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home St Residance 6 Other (Specify) 10 1 Yes 2√ No this 27. Manner of Death 28a. Date of Injury (Month, Day Yaar) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Attending After Division 1 Natural 2 ☐ Accident 5 Panding investigation i or Attendin s efter death. I Director: Aft d in by the fu 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital o within 24 hours eff To the Funeral DI completaly filled in 29a. Certifier Medicai 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mahner stated. 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 EDS7 Carrol fine Station H 10+ St Spaisbury An 21801 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Julia Davidson-Randall Registrar IAN 2 0 1998

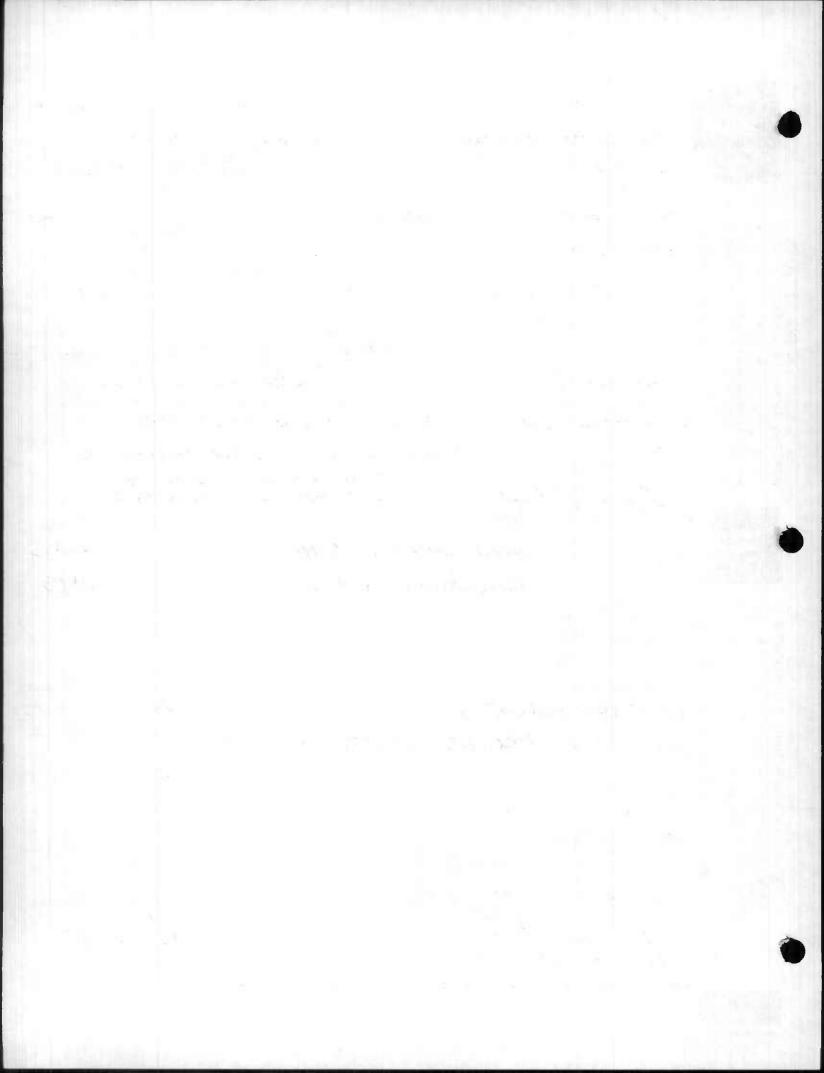


						Ce	rtificate	OI I	Jeani			Reg	g. No.		160	
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kamin	er	4a. Facility Name (If not ins	- 11/1					4			ocation of D	Death	4c. County			
	-	THE MEMO 5. Social Security Number		L HUSP.		rs. last birthday)	If Under 1	Year	EAS'		8. Date o	f Birth	TALBO		ace (State	or Foreign
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of at		10a. State 10b. C			10c. 0	City, Town or Lo	ocation							10	d. Inside C	ity Limits
fedat	to	MD C	arol:	ine		Hender	rson								1 🗆 Yes	20No
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State

Registrar

JAN 20 '98



7. Aga (In yrs. last birthday)

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Yrs.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth January 13 1998 1335 Doretta J. Purnell

4b. City, Town, or Location of Deeth

SALISBURY

4. County of Death

WICOMICO

Birthplace (Stete or Foreign Country)

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

4a. Facility Nama (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

1 M 2 F

Funeral Director

the Maryland

10a Stete 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Director Worcester Berlin 10e. Street end Number 10f. Zip Code 113 Bowen Circle 21811 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Wes Dacedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 2 should be filed within 72 hours after and Mental Hygiene. 1 □ Never Married 2 □ Married 1 Yes 2 XNo Specify: þ 3 ☐ Widowed 4 N Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 214-60-9147 Elementary/Secondary (0-12) College (1-4or 5+) Private Housekeeper permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If flem 27 is marked othe any injury or other traumatic event, 9069. 17. Fathar's Name (First, Middla, Last) Be George Purnell 19a. Informant's Name/Relationship (Type, Print) Latrice Purnell/daughter 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetary, cremetory or other place) 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Pauls Cemetery 21. Signeture of Funeral Service Licensee Physician /Medical Immediate Cause (Final diseese or condition resulting In death) Examiner Due to (or as e consequance of). Examiner sician and burial-transit Sequantielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Dua to (or as a consequence of): physician s the burial Physician/Medical Due to (or es a consequance of): as attending p signed by the a Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. à Completed been s has page 2 Division of Vital director, 25. Was cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2No P funeral 27. Manner of Death 28b Time of 28c. Injury et Work? Certification: After 5 Pending Investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No i or Attend after death Director: / 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral D 29a. Certifier Medical completaly (Check only one) To the F within 2 To the F

Chasse

M.D.

This Studen Redall

32. Registrer's Signeture

Kobert

31. Date filed (Month, Day, Year)

JAN 16 1998

214-60-9147 MD Usuel Residence of Decedent 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of Whet Country? U.S. 14. Race - American Indien, Bleck, White, atc. Specify: Black 16h. Kind of Business/Industry Service 18. Mother's Name (First, Middle, Maiden Sumame) Maggie Briddell Purnell 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 106 Wicomico St., Apt. 303, Ocean City, MD 21842 20c. Location - City or Town, State 1/17/98 Berlin, MD 22. Name and Address of Facility
Lewis N. Watson Funeral Home 23a Part Lenter the disease, of complications that caused the deeth. Do not antar the moda of dying, such as cerdiac or raspiretory errest, how, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death 23b. Did tobecco use contribute to the cause of deeth? 1 Yes ANO 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? 24a. Wes en eutopsy parformed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 28d. Describe how injury occurred 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of fertifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

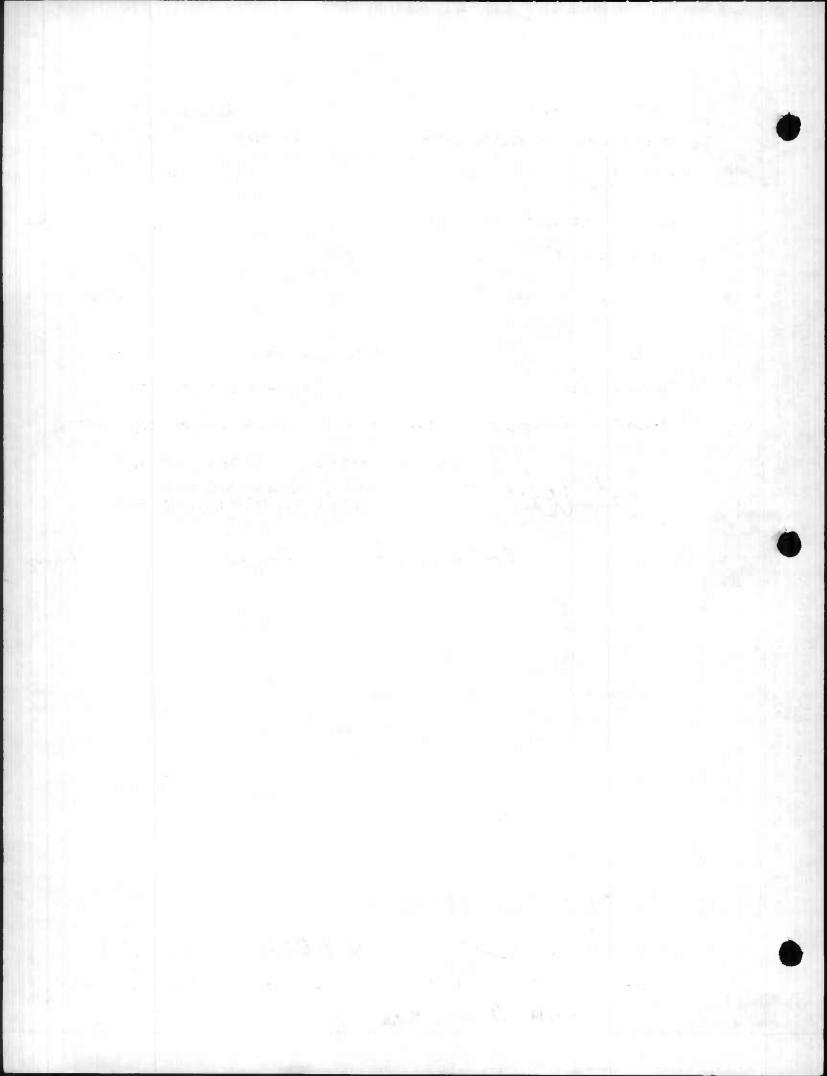
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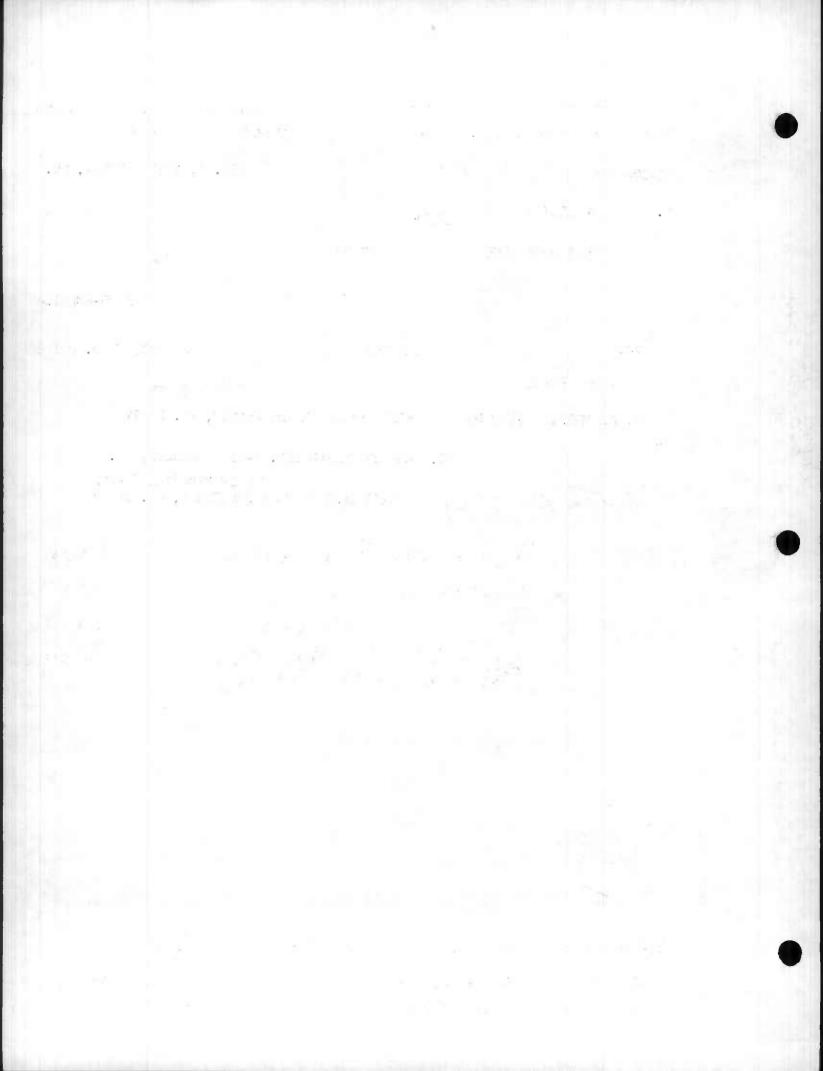
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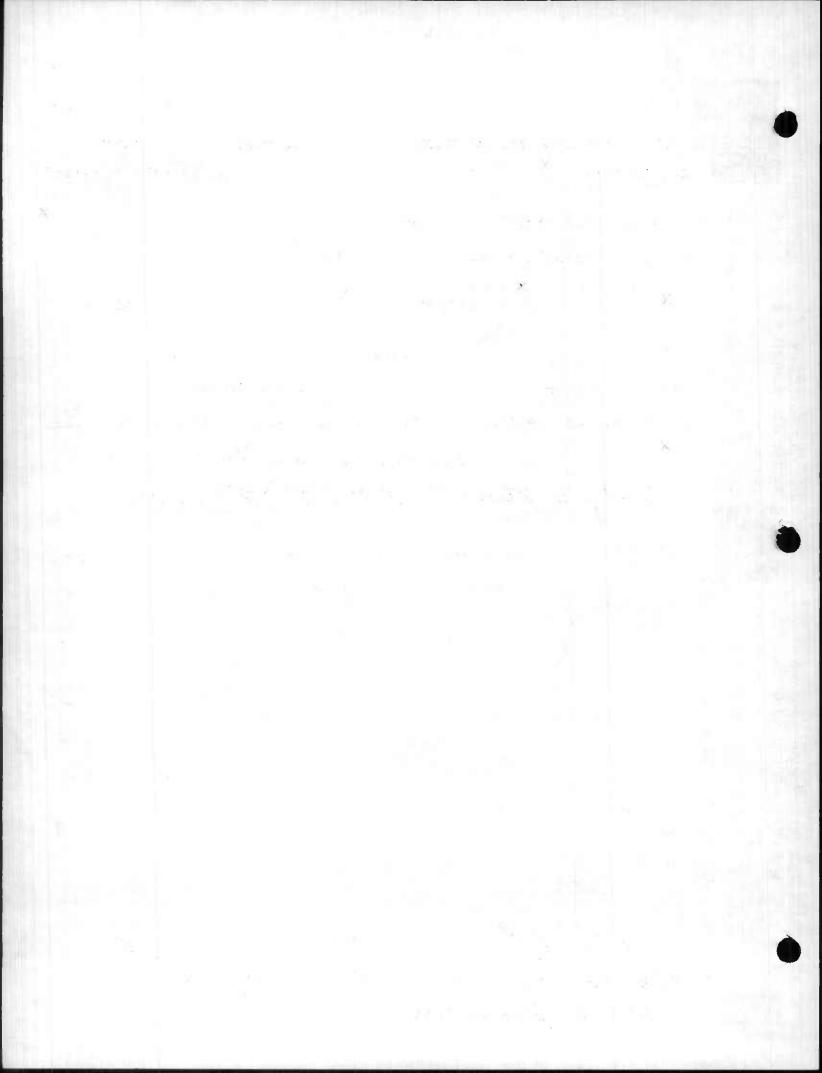
State of Maryland / Department of Health and Mental Hygiene 98

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6	30. Name and address	of person who o	completed ceusa of	daath (Item	1 23a) (Type, P	rint)			1	~ '	100



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Name (Fir.	st, Middle, Le	st)						12.	Dete of Dee	th		3. Time of De
Physicia /Medic Examin	al		Hubert	t Pars					4b. City, Town	J	Month	1 12	Yeer 1998 y of Death	1418
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be filed within 72 hours effer death with the Maryland ital Hygiene. d other than "netural", or itams 23a or 28a-f show event, the Med cal Examinat must be notified at	Funeral Director	Maryland 10e. Street and Number 27002 S.To 11. Maritel Status	Wicon		rive	bron J,s. 13.		ip Code 218 edent of Fecify Cub	30 Hispenic Origin	? (Specification Rice		U.S.A		ry? en Indien,
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State of Maryland / Department of Health and Mental Hygiene

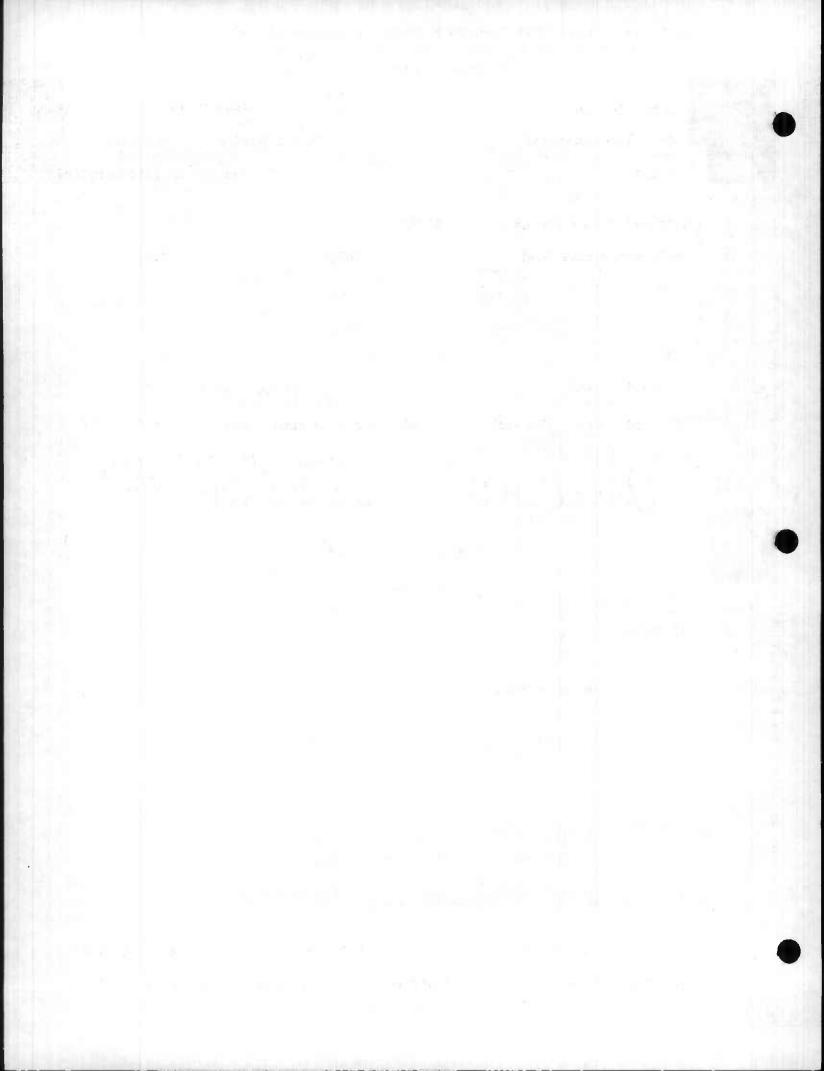
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State of Maryland / Department of Health and Mental Hygiene 98 02833

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filed within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or items 23a or 28a-f show ont, the Medical Examinat must be notified at	Funeral	1 Never Marriad 2 ☐ Married	Armed Forca:	s?	If Yes, sp	ecify Cul	oen, Mexicen, Puert	o Rican, etc.)		ack, White,	etc.
semit. Pages 1 and 2 should be filed within 72 hours at Department of Heelth and Mental Hygiene. The mortant: If Item 27 is marked other than "natural", or my injury or other traumatic event, its West call Exam	by	3 □ Widowed 4 □ Divorced	If Yes, Give		1 ☐ Yes	28 No	Specify:		Spec		
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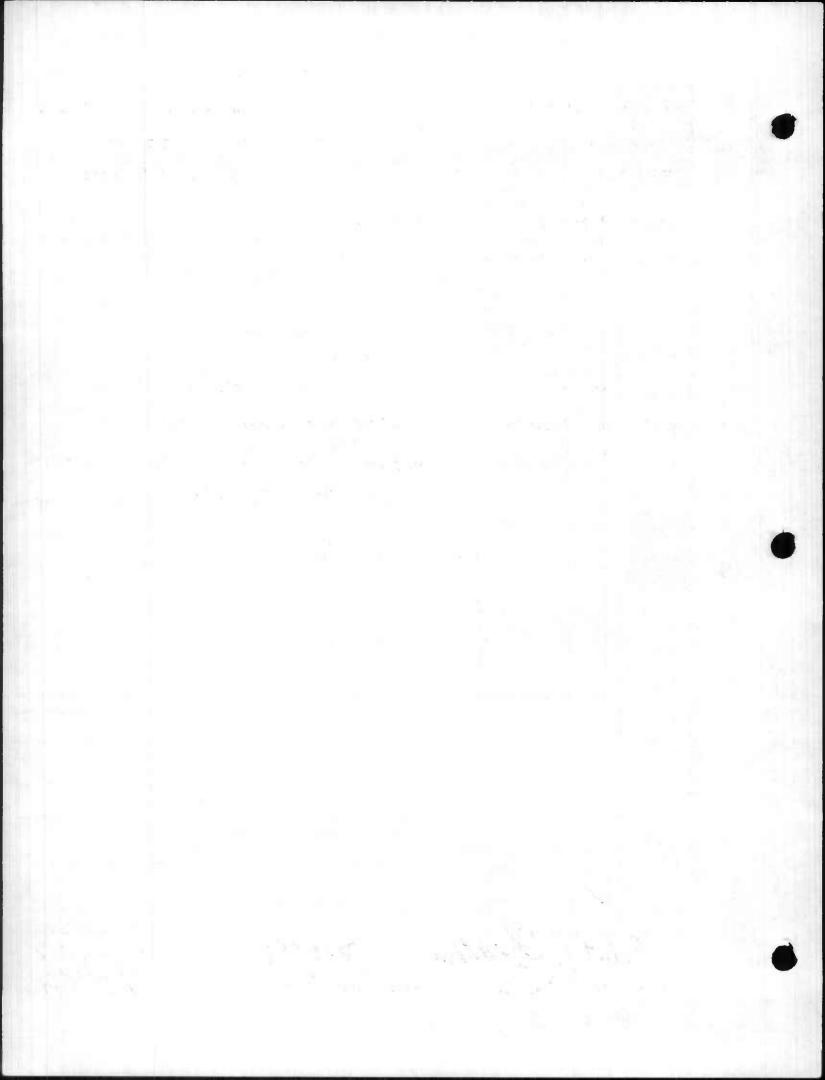
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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aminer		4a. Facility Nama (If not Institution	on, giva s	treet and num	iber)						cation of Death	4c. County		
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eral ctor		5. Social Security N 323-56-38 Usual Rasidanca o	345	6. Sax	M 2 F	7. Aga (In yrs 97	(last birthday) Yrs.	Months	r 1 Yaar Days	If Undar Hours	24 Hrs. Min.	8. Data of Birth Month, Day February	9, 1900	9. Births Cour WTSC	placa (Stata or Fi ntry) ONSIN
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and or	5	Maryland	Monto	omer	·v		ithers								1 🗆 (Yas 2)
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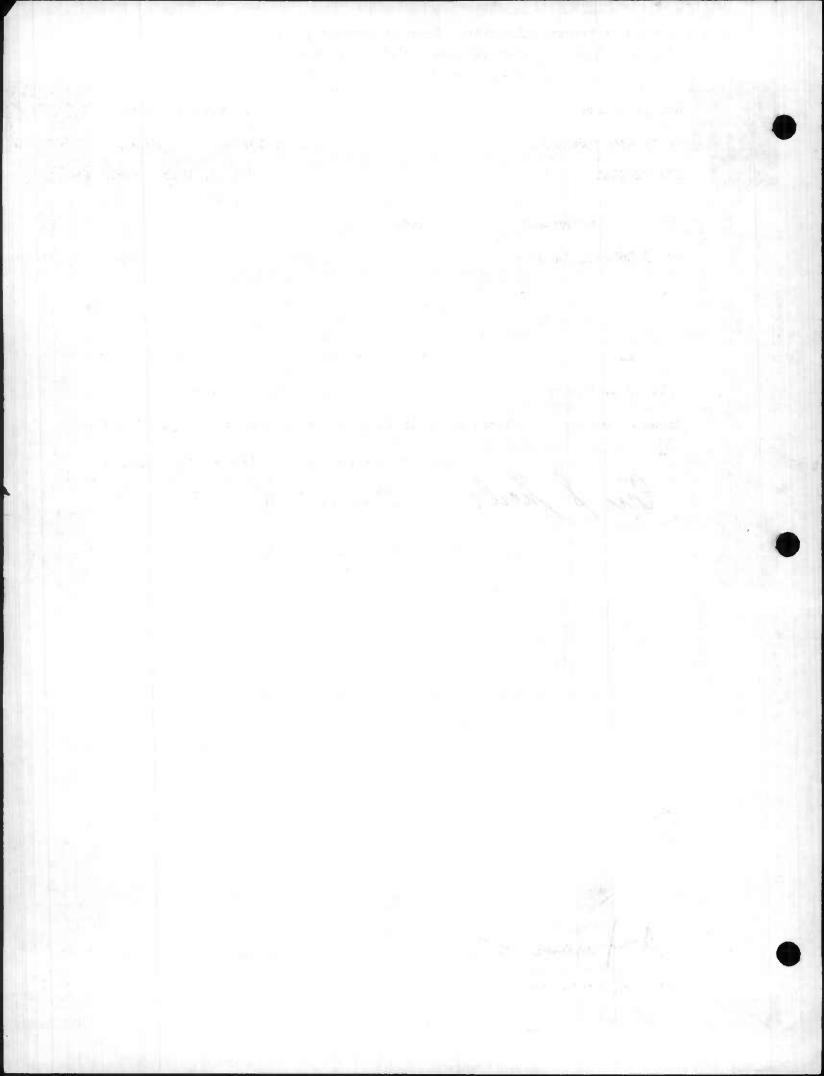
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	e Ho.	edical		al Exa	niner: On tha b	pasis of	axamination	and/or in	nvestigetlon,	In my o	ppinlon, death o	occurrad at tha the	ma, data	and place,	and due to	tha cau	se(s)
	ro th omp	Me	29b. Signatura and title of cen	ifiar			1,000		29c.	Licans	sa number		29d.	Data signe	d (Month,	Day, Ye	ar)
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	1011		20 Name and add	MA		m		la) (T	Date 1		フレン	02		44	0)-	19	93
			30. Name end addrass of pers	on who	A 1	se of de	eath (item 23	a) (Type	, erint)		Λ	32 # 2	20		00	2	2
			31. Data filed (Month, Day, Ya	A	201	Registre	ar's Signature	an	eore	Joseph Contraction of the second	7 the	- SIC	NE	R S	CIL	14	
	Sta		JAN 21	000	List.	Togistra	a s signature	and of	2								
	Registr	ar	TRAMO	330	June	- WW	forma and	-									

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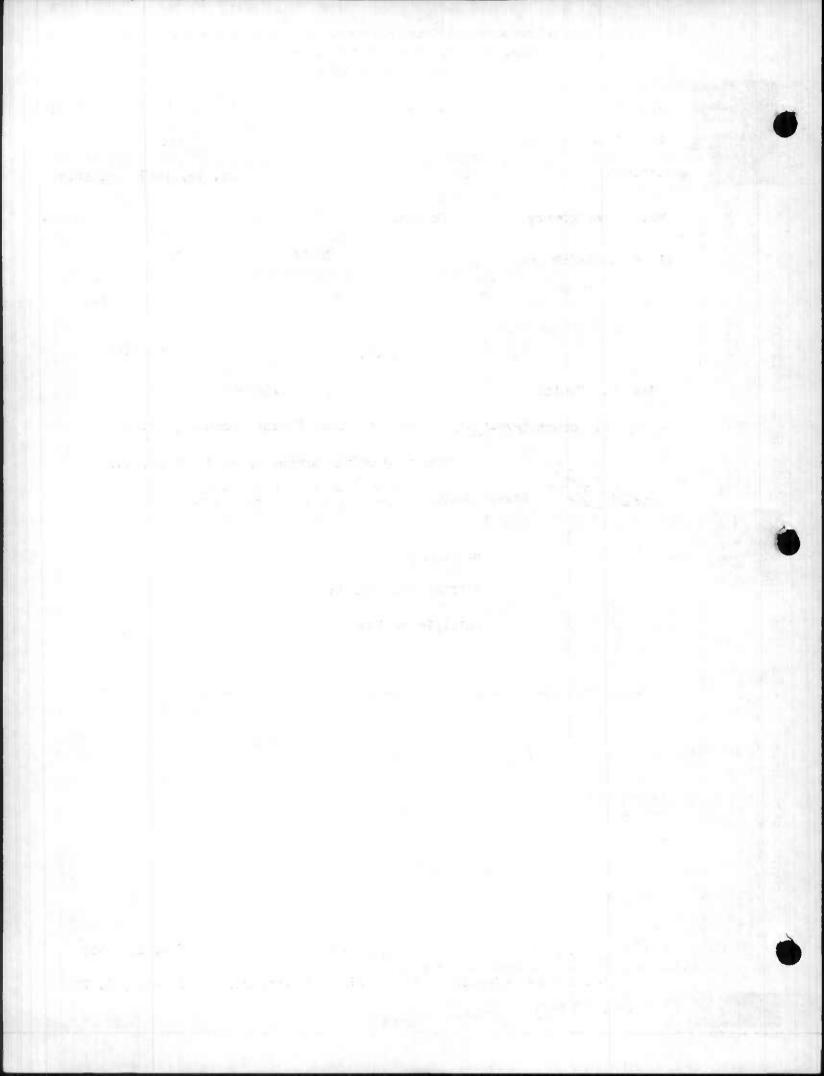


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month MARTIN F REDLER 1998 6:00AM JAN. 15. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 11814 PRESTWICK ROAD POTOMAC MONTGOMERY If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Birthplece (State or Foreign Country) Months Days **™** M 2□ F Yrs 50 Director 494-50-6899 Oct. 16, 1947 Missouri Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. tnslde City Limits 28a-f show Examiner must be notified at Director 1 Yes 2 No Montgomery Potomac 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 1 6 23a 20854 US death 1 11814 Prestwick Road Funeral Herns 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, pemit. Pages 1 end 2 should be filed within 72 hours efter Department of Health end Mental Hygiene. Important: If Item 27 is merked other than "natural", or thei any injury or other traumetic event, the Medical Examina-Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ Mo Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounting C.P.A. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Max W. Redler Florence 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9200 Gatewater Terrace Potomac, Md. 20854 Joseph P. Bornstein/B-N -L 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 □ Donetion 5 □ Other (Specify) Judean Memorial Gardens 1/16/98 Olney, Md. 21. Signeture of Funerel Service bicenses 22. Name end Address of Fecility EDWARD SAGEL FUNERAL DIRECTION Edward Sagel 1091 ROCKVILLE PIKE - ROCKVILLE, MD. 20852 23a. Pert1. Enter the discase, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Pneumonia Examiner Due to (or es e consequence of): Examiner Febrile neutropenia the death certificate be executed physician end the buriel-trensit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Box 68760. Multiple Myeloma Physician/Medical Due to (or es e consequence of): asi USe a for signed by the e P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, P A 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed The law pege 2 s 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4☐ Nursing Home 5 Aresidence 6 ☐ Other (Specify) Certification: To 1 Yes 2N No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 5 Pending 1X Neturel deeth. Investigation 1 ☐ Yes 2 ☐ No 2 Accident efter deet Director: 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homloide in 24 hour.
The Funeral Direction Hospital Certifying Physictan: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

| Madical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. edicai 29e. Certifier completely (Check only one) within 2 the th 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 2 Chitic 20 D42452 Jan. 15, 1998 7/0 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Chitra Rajagopal 18111 Prince Phillip Dr. #327 Olney, Md. 20832 31. Date filed (Mg) No Pay 200 32. Registrar's Signeture State hie Davidson

Registrar **DHMH 16 Rav 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month 12, 1998 H. Robinson January 8:15 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 9616 East Bexhill Drive Kensington Montgomery If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1 □ M 2 🖾 F Months Deys Yrs. 91 September 9, 1906 Utah Usuel Residence of Decedent 10b. County 10c. City. Town or Locetion 10d. Inside City Limits 1 ☐ Yes 2 No Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 9616 East Bexhill Drive 20895 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Nidowed 4 Divorced Decedent's Usual Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First Middle Meiden Surname) Charles Hickman Lettie Ann Mikesell 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 93105 Karma R. Pincock/Daughter 1575 Las Canoas Road, Santa Barbara, California 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) January 22, 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M00846 that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, the capito on each line. Approximete Intervel Between Onset end Deeth Carcinoma of the Ovary 1 Year Due to (or as a consequence of): Due to (or es e consequenca of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2K No 3 Probably 4 Unknown 24e. Wes an autopsy performed?

January (3, 1998

Baltimore, Maryland 21215-0020 **Physician** /Medical **Examiner**

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physician

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page 2 :

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certificate

After this funaral

Hospital or Attending Physician:

death. i Director: A d in by the fu

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The law requires that the death certificete be axecuted

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed will Department of Health end Mental Hygien. Important: If Item 27 is marked other that sany Injury or other traumatic event, It all the page 1.0 miles of the traumatic event, It all the progressions of the present of the traumatic event, It all the present of the traumatic event, It all the present of the prese

the Medical Examiner must be notified at

Director

Funeral

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Completed

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filed within 72 hours efter death with the Maryland

5. Sociel Security Number

219-68-6917

10a Stete

Maryland

10e Street and Number

20e. Method of Disposition

Examiner Physician/Medical p Be Completed 2 Certification:

21. Signature of Funeral S Part1. Enter the disease shock, or heart failure. Immediete Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Congestive Heart Failure 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 2 🖾 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. injury et Work? 28d. Describe how Injury occurred 1 Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29e. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

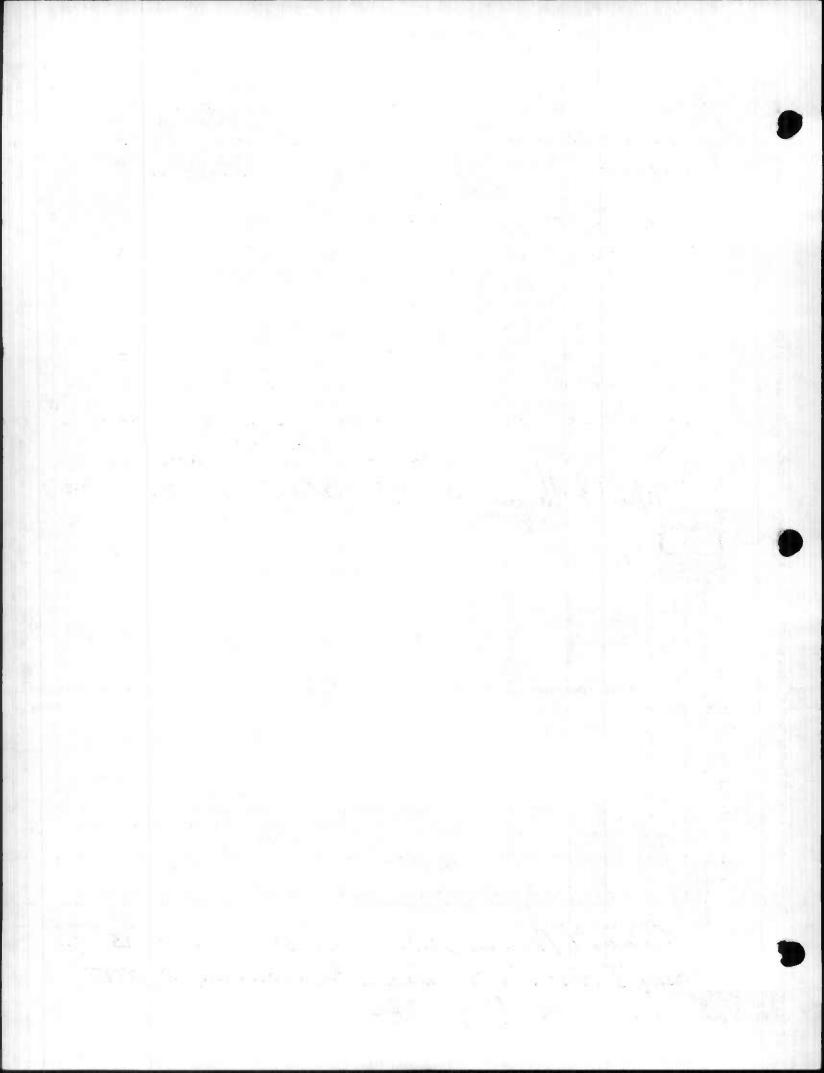
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer)

To the Hospital o within 24 hours aft To the Funerel Di completaly filled in

State Registrar 31. Dete filed (Month, Day, Year)

20 JAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wesley B. Mason 10810 Connecticut Ave, Kansington, MD, 20895 32. Registrer's Signature



REDDING LINDY

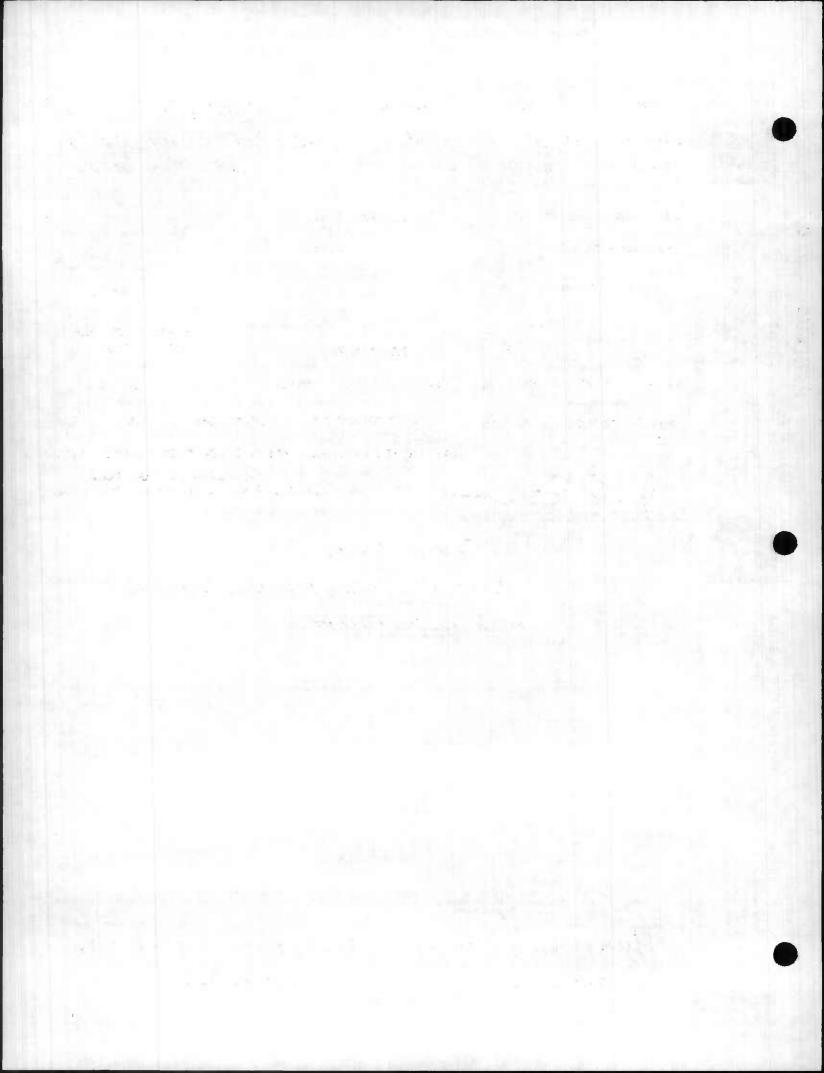
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death **Physician** 11:10Pm LINDY MARK REDDING, JANUARY JR. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNIE AA. COUNT HOSPITAL NORTH ARUNDEL 8. Data of Birth (Month, Day, JUNE 18 5. Social Sacurity Number 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. last birthday) Yaar) 1955 MARYLAND **Funeral** Days XOM 20F Months 213-64-0333 Director Usual Rasidance of Decedant 10a. Stata 10c. City. Town or Location 10d Inside City Limits 10b. County 7 is marked other than "naturel", or flems 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1 Yas 2 No MARYLAND ANNE ARUNDEL Director SEVERNA PARK 10e. Street and Number 10f. Zip Coda 10c. Citizan of What Country? 580 MANOR ROAD 21146 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 11 Marital Status 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☐ No If Yas, Giva Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Il Hygiene. other than "naturel", Year or Dates: Completed 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry HEATING AND AIR Elamentary/Secondery (0-12) College (1-4or 5+) CONDITIONING SERVICE MAN 12 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maldan Sumama) Be Pages 1 and 2 should be family of the thank of the th and Mantal is marked of LINDY MARK REDDING. SR. ANITA HAZEL **RAVALO** 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 300 REGENCY CIRCLE, LINTHICUM, MARYLAND 21090 ANITA REDDING (MOTHER) altimore, 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Data 20c. Location - City or Town, Stata GLEN HAVEN MEMORIAL PARK 1/21/98 GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, 21 Sint 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 END Entar tha disaasa, or complications that ceusad tha death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, or haart failura. List only one causa on each line. Approximata Intarval Batwaan Onset and Death 23a. Part 1 **Physician** /Medical Mediata Cause (Final disaasa or condition rasulting in death) Examiner T RESPIRATORY DISTRESS SYNDROME Due to (or es e consequence of): Examiner certificata be axecuted Sequentially list conditions, if any, leeding to Immadiata couse. Enter Underlying Cousa (Disease or injury that initiated avants rasulting in death) Last end burial-tran Division of Vital Records, P.O. Box 68760. physician RENAL Physician/Medical tha ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No à 3 Probably 4 Unknown signed i PV 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was en eutopsy page 2 1 Yas 1 Yas 2 No 2 No or Attending Physician: aftar deeth. Director: After this certific funeral director, Be 25. Was cesa rafarrad to medical 26. Placa of Deeth (Chack only one) axaminar? 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 27. Manner of Daath 28a. Data of tnjury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Neturel 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be determined 3 ☐ Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Cartifian (Check only one) To the Within 2 To the 29b. Signature and title of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Yaar) Dr. Oke muji for e and addrass of person who completed causa of deeth (Item 23a) (Type, Print) AYOKU OKETUNJI, M.D., 301 HOSPITAL DR., GLEN BURNIE, MD. 21061

32. Ragistras Signatura Randalle

State Registrar 31. Date filed (Month, Day, Year)
JAN 22 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** ache 5:00 PM 20 1998 nomas January /Medical 4b. City, Town, or Location of Death 4c County of Death 4a Facility Neme (If not institution, give street and number) Examiner nne H Hosp, to 7. Age (In yrs. last birthday) Cunde 6 8. Date of Birth MAY 27, 1924 5. Social Security Number oct nde 9. Birthplace (State or Foreign Sex 1 M 2 □ F **Funeral** Months Days Hours NORTH CAROLINA 73 Yrs. 237-32-7220 Director Usual Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No GLEN BURNIE MARYLAND ANNE ARUNDEL Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 21061 U.S.A. 204 OAK LANE N.W. Funeral 12. Was Decedent Ever in U,S. Amped Forces? 1 △ Yes, 2 □ No If Yes, Give Year or Datas: 1946-49 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 🗓 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. Collega (1-4or 5+) Elamantary/Secondary (0-12) ASSEMBLY LINE WORKER GENERAL MOTORS 11 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be CAROLINA BRIGMAN BELVIN RACHELS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 204 OAK LANE N.W. GLEN BURNIE, MARYLAND 21061 Health Hern 27 i JANE RACHELS WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locetion - City or Town, Stete 20e. Method of Disposition Pages to 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GLEN HAVEN MEMORIAL PARK 1-23-1998 GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061 23a. Part1. Enter the disease or complication, thet caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each lina. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final disaasa or condition rasulting in daath) Examiner Due to (or as a consaquence of) Examiner physician end the burial-frensit thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceusa. Entar Underlying Causa (Diseasa or Injury Due to (or as a consequence of): P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of) attending pl for use es t signed by the aid be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 No 25. Was cesa raferred to medical axaminer? Be 26. Placa of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident or Attending 5 Panding 1 Yes 2 No death. investigation ector: 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide efter the Funeral Direction 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier edicai (Check only within 2 To the f 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier M. M. 30. Name and address of person who complated cousa of death (Item 23a) (Type, Print)

State Registrar

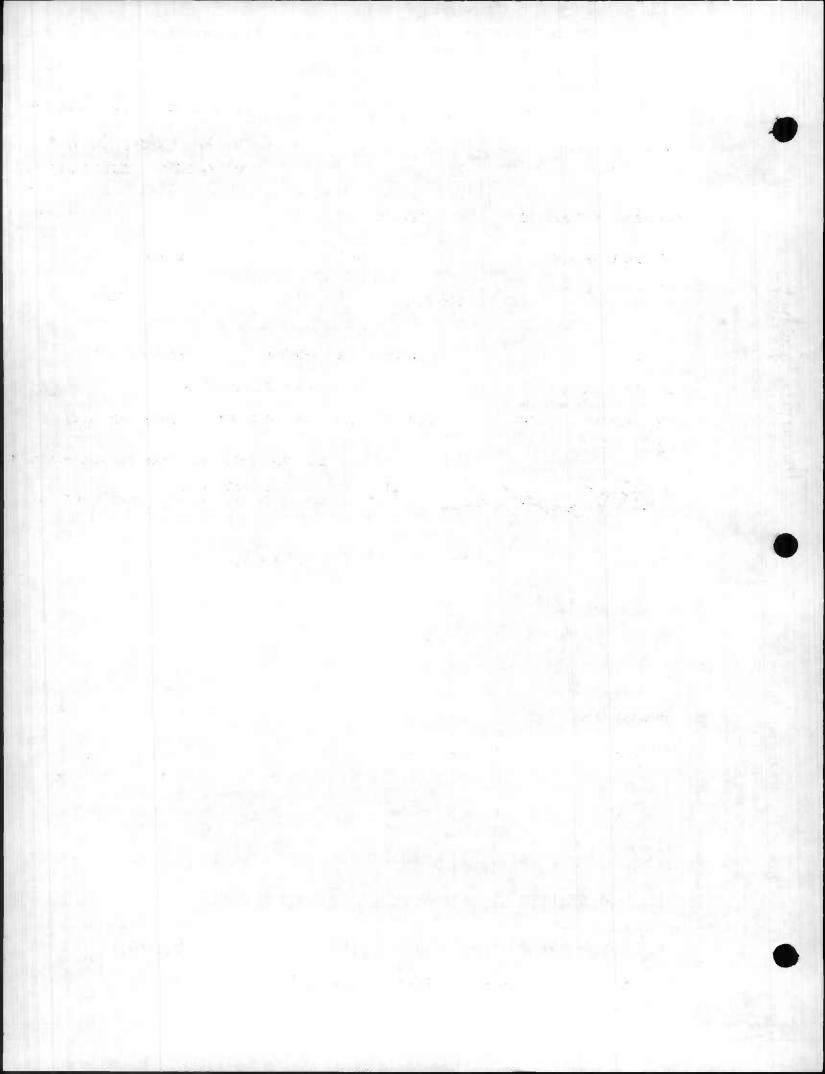
DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) JAN 22 1998

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32. Registrar's Signature Julia Davidson Randell

Nork



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daath Day Month ALVERTA D. ROBINSON 1:30 am JAN. 14 1998 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 461 MANSE COURT BALTIMORE 5. Social Sacurity Number If Under 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yaar) Birthplaca (Stata or Foreign Country) 1 M 2004 Days Yrs. 217-26-1835 84 JULY 1 1913 MARYLAND Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Yas 2 No MARYLAND CITY BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21201 461 MANSE COURT 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Giva Year or Detes: Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Raca - American Indian, Black, Whita, atc. 1 ☐ Navar Manied 2 ☐ Married 1 ☐ Yas 2 No Specify: BLACK Specify. 3 Widowed 4 □ Divorced Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) FOSTER GRANDPARENT 10th ANNE ARUNDEL COUNTY 17. Fathar's Name (First, Middla, Last) 18. Mother's Nema (First, Middla, Maidan Sumama) WARDELL DAY FLORIDA HONIE 19a. Informant's Name/Ralationship (Typa, Print) 19b. Meiling Addrass (Straat and Numbar or Rural Route Number, City or Town, Stata, Zip Coda) 461 MANSE COURT BALTIMORE, MD. 21201 PATRICIA WRIGHT (DAUGHTER) 20b. Place of Disposition (Nama of comatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) ASBURY BROADNECK CEMETERY 1/24/98 ST. MARGARETS, MD. 21. Signatura of Funaral Sarvica Licensea 22. Name end Address of Facility WM. REESE & SONS MORTUARY, P.A. Entar tha disaase, or complications that causad tha daath. Do not anter the mode of dying, such as cardiac or raspiratory errast, c, or haart faiture. List only ona causa on each lina. Approximate Interval Batwaan Onsat and Daath Immediata Cause (Finel Probable Myocardial disease or condition rasulting In death)

Physician /Medical **Examiner**

To the Hospital or Attanding Physician: The lew requires that the death certificate be executed within £4 hours effect death.

To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funerel director, page 2 should be deteched for use as the burial-transit

Records, P.O. Box 68760,

Division of Vital

permit. Pages 1 end 2 s Department of Health er Important: If item 27 is any injury or other trau

Physician

/Medical

Examiner

10e State

Funeral

Director

28a-f show

items 23a or 28a-f showing must be notified at

traumatic event, the Medical Examiner.

Pages 1 end 2 should be filed within 72 hours after nent of Health end Mental Hygiene. int: If Item 27 is marked other than "natural", or Ite

Baltimore, Maryland 21215-0020

death

Director

Funeral

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Completed

Be

Physician/Medical Examiner PV Be Completed Certification: To

	Dua to (or es e consequance of)	•		
Saquantially list conditions, if any, laading to immediata cause. Enter Undartying Ceuse (Disease or Injury that initiated evants	b Due to (or as a consequence of)	:		1
Ceuse (Diseasa or Irijury that initiated evants resulting in daath) Last	Dua to (d	or as a consequance of):			
Part II. Other significant conditions o	ontributing to death but not re-	sulting in the underlying	causa givan In Part I.	23b. Did tobecco use co 1 ☐ Yes 2 ☒ No	ntribute to the cause of death
				24a. Was an autopsy performad?	24b. Were autopsy findings available prior to completion of cause of death?
				1 ☐ Yas 2 🗷 No	1 ☐ Yes 2 ☐ No
25. Was casa referred to medical axaminer?			26. Plece of D	eeth (Check only one)	
1 ☐ Yas 2 🖫 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ D	OA Othar: 4 Nursing	Homa 5 A Rasidenca 8 □Oth	nar (Specify)
27. Mannar of Death 1 ⊠Naturel 5 ☐ Pending 2 ☐ Accident Invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury M	28d. Dascribe how injury occur	red	
3 ☐ Suicide 6 ☐ Could not be datermined	28a. Pleca of Injury - At h building, etc. (Speci	28f. Location (Straat and Numb City or Town, Stata)	ber or Rural Route Number,		

State Registrar

edical

29a. Cartifier

29b. Signatura end titla of certiful

31. Data filad (Month, Day, Yaar)

JAN 22

29c. Licensa number D 16964 MY

1x Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, data and placa, and dua to tha causa(s) and menner es steted.

2 Medical Examinar: On tha basis of exemination and/or invastigation, in my opinion, daath occurred at the tima, data and placa, and dua to tha cause(s) and manner stated.

29d. Data signad (Month, Day, Yaar)

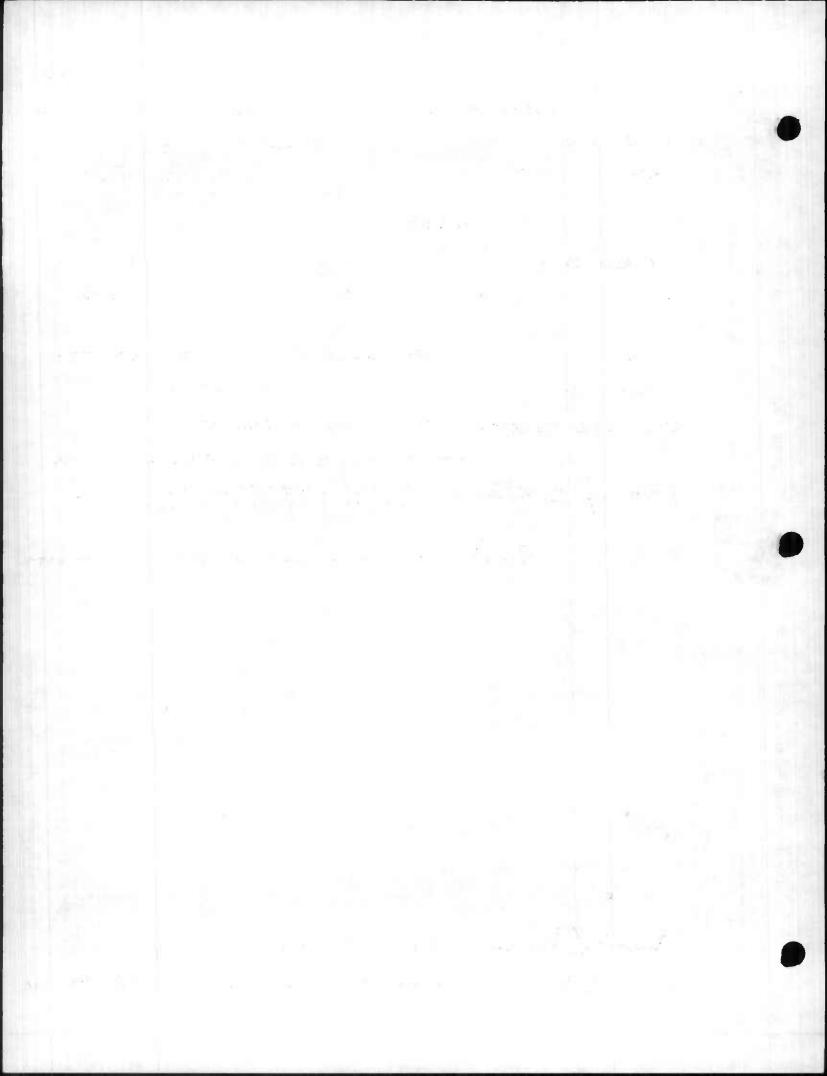
Ritches Huy Arnold, WR21012

30. Name end addrass of person who complated ceuse of death (Item 23a) (Type, Print)

ames acous 1509

32. Ragistrar's Signature

Via Daydson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Ridinger Margaret 0/20 Jan /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Howard Howard County COlumbi If Under 24 Hrs. 8 Hospita Genera a 7. Age (In yrs. lest birthdey) 86 Yrs. 5. Social Security Number If Under 1 Year Birthplece (State or Foreign _Country) **Funeral** Days Hours 1 □ M 2 X F 214-14-4822 Director Aug Md. Usuel Residence of Decedent the Marylend 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examiner must be not and Md. Carroll Sykesville 1 ☐ Yes 2 🔀 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 end 2 should be filed within 72 hours efter death with t Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itema 23a or 2 and plijury or other treumatic event, the Medical Examinat must be an once. 1307 Terrace Court 21784 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 12. Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) owner/manager retail card shop 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Mary Ellen Lillis John Casey 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary Margaret Schwaab (daughter) 1307 Terrace Ct. Sykesville, Md. 21784 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Crest Lawn Memorial 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetlon 5 ☐ Other (Specify) 1-22-98 Marriottsville, Md. 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784 Ut m Brian tu 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel + cate myo cardial minutes disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Cardiovascular disease Years therosclerotic sician end buriel-trensit be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of) physician es the buriel P.O. Box 68760 Physician/Medical Due to (or es e consequence of) esn Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached signed by t 1 Yes 2 No 3 Probably 4 Unknown pertension Division of Vital Records. p 24b. Were autopsy findings aveilable prior to completion of cause of death? plnods Completed 24e. Wes en eutopsy hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certified funeral director, 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ♣Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 28b. Time of 5 Pending investigation 1 SNaturei 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piace, end due to the ceuse(s) end menner steted. 29a. Certifier Medical

29c. License number

D38252

Drive Columbia, mo

29d. Date signed (Month, Dey, Year)

1998

State Registrar

29b. Signature end title of certifier

30. Name end eddress of person

31. Dete filed (Month, Dey, Year)

Farb, mo

JAN 2 1 1998

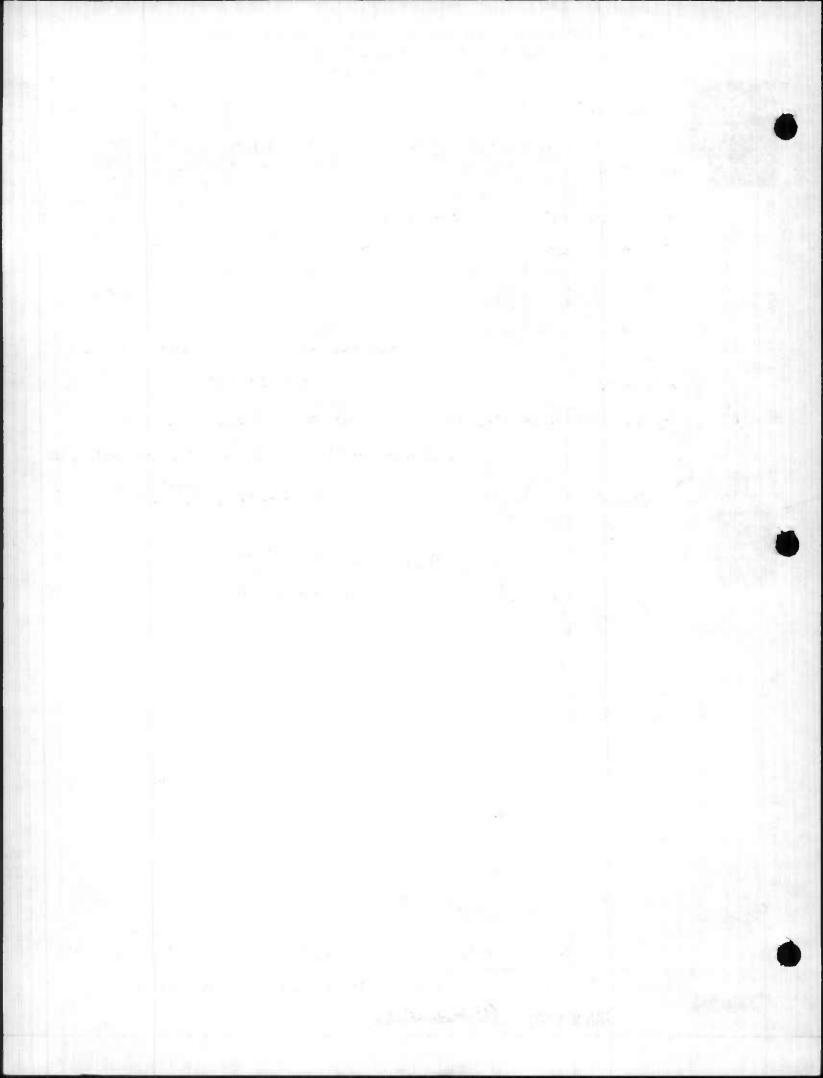
marew

M.O.

who completed ceuse of deeth (Item 23e) (Type, Print)

6259 Audubon

32. Registrer's Signeture



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Leroy James Root 18, 1998 8:30 PM January 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 20310 Gilliam Drive Park Hall St. Mary's If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Devs Hours Min. (Month, Dev, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) Months Deys Hours 1 M 2 F Yrs. 390-14-3027 76 June 7, 1921 Wisconsin Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland St. Mary's Park Hall 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 20310 Gilliam Drive 20667 United States 14. Raca - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Status Black, White, etc. 1 ■ Yes 2 □ No If Yes, Give Yeer or Dates:1941-1962 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: 3 ■ Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Noncommissioned Officer Defense 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Robert J. Root Lena M. Hefty 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Melody Visele, Daughter 20310 Gilliam Drive, Park Hall, Maryland 20667 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ■ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 1/24/98 Alexandria, Virginia 22. Name end Address of Fecility alus Brinsfield Funeral Home, P.A. Edward N. Brinsfierd, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Approximate Interval Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) 2 geo Due to for es e consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequença of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings evelleble prior to 24a. Wes en eutopsy performed?

Physician /Medical Examiner

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signed by the a

page 2 has

certificate

this funeral

s after death.

6 Hospital 24 hours

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Medical

the death certificate be executed

Division of Vital Records,

Physician

/Medical

Directo

Funeral

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Hygiene. uther than "natural", or items 23a or 28a-f ahow ant, the Medical Examiner must be nortified at

nd 2 should be filed vilth end Mental Hygie 27 is marked other r traumatic avant, II

permit. Peges 1 and 2 Department of Health e important: If item 27 is any injury or other traingnes.

the Manyland

Maryland 21215-0020

altimore,

Examiner Physician/Medical þ Completed Be To Certification:

25. Wes case referred to medical examiner?

29b. Signature and title of certifier

David Allen, M.D.

1 Yes 2 No

27. Menne of Deeth

2 Accident

4 Homlcide

(Check only

3 ☐ Suicide

29a. Certifier

1 ☐ Yes 2 ☐ No

completion of cause of deeth? 1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one) Other: 4□ Nursing Home 5 Residence 6 □ Other (Specify)

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the countries of the time, date end placa, and due to the countries of the time. mination end/or Investigation, In my opinion, deeth occurred at the time, date end placa, and due to the cause(s) 29c. License number

28c. Injury et Work?

29d. Date signed (Month, Day, Year)

of deth (Item 23e) (Type, Print) 30. Neme end eddress of person who completed cault

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28e. Dete of Injury (Month, Dey Year)

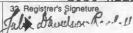
2050 Wildewood Court, California, Maryland 20619

Registrar

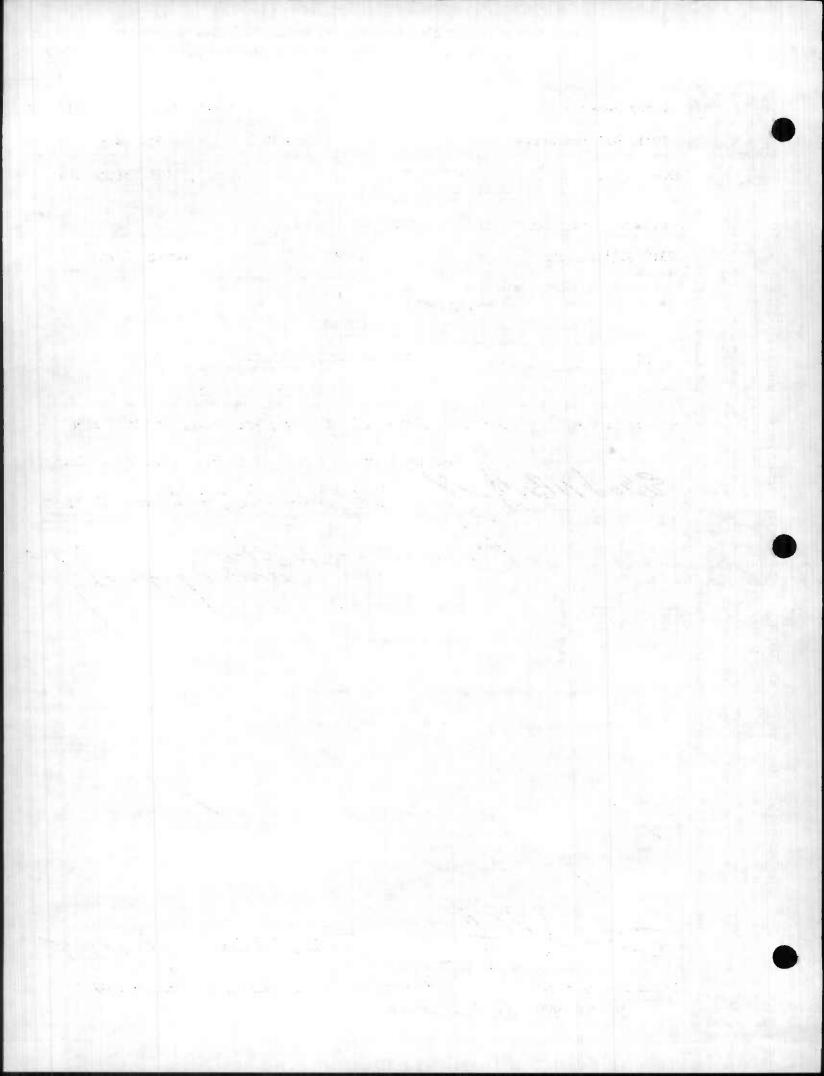
31. Date filed (Month, Dey, Year) JAN 26 1998

5 Pending Investigation

6 Could not be determined



DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** 22, 1998 4c. County of Deeth Eugenia Martin Reis 4b. City, Town, or Location of Deeth 11:50 AM /Medical 4a Fecility Neme (If not institution, give street end number) Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1□M 200F Min Months Deys Hours Yrs. Director 136-01-5248 91 January 24, 1906 Spain Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 ■ No Directo Maryland St. Mary's St. Mary's City 10g. Citizen of What Country? 10e. Street end Number r than "natural", or items 23s or the Wedical Examiner must be r P.O. Box 82 Funeral 20686 United States death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indien, Bleck, White, etc. 11 Maritel Status filed within 72 hours after 1 ☐ Yes 2 ■ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Spain altimore, Maryland 21215-0020 White þ 3 ■ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinger of Health end Mantal Hygiena.
nt: If Item 27 is marked other than Sewing 12 Seamstress 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 7 is marked of traumatic even Felipe Martin Arribas Remedios Garcia Rojo 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abel M. Dominguez, P.O. Box 82, St. Mary's City, Maryland 20686 SOn Item 2 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete permit. Pages
Depertment of
Important: If it
any injury or o 1 ■ Buriel 2 Cremetion 3 Removal from State 4 □ Donetion 5 □ Other (Specify) Charles Memorial Gardens 1/24/98 Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Mi hael K. Blankens 23a. Pentl. Enter the disease, or complications the shock, or heert failure. List only one cause 22955 Hollywood Road, Leonardtown, MD 20650 Blankenship ed the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) 2-3 days Examiner Examiner attending physicien end for use as the bunal-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequença of) ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evaileble prior to 24a. Wes en eutopsy performed? Completed completion of cause of deeth? ls certificata has director, page 2 2 NO 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese referred to medicet exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident Director: A 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filted in by edical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of certifier mpleted cause of deeth (Item 23e) (Type, Print) 30. Name end address of person who co James C. Boyd, 31. Dete filed (Month, Dey, Year) 2050 Wildewood Court, California, Maryland 20619 State

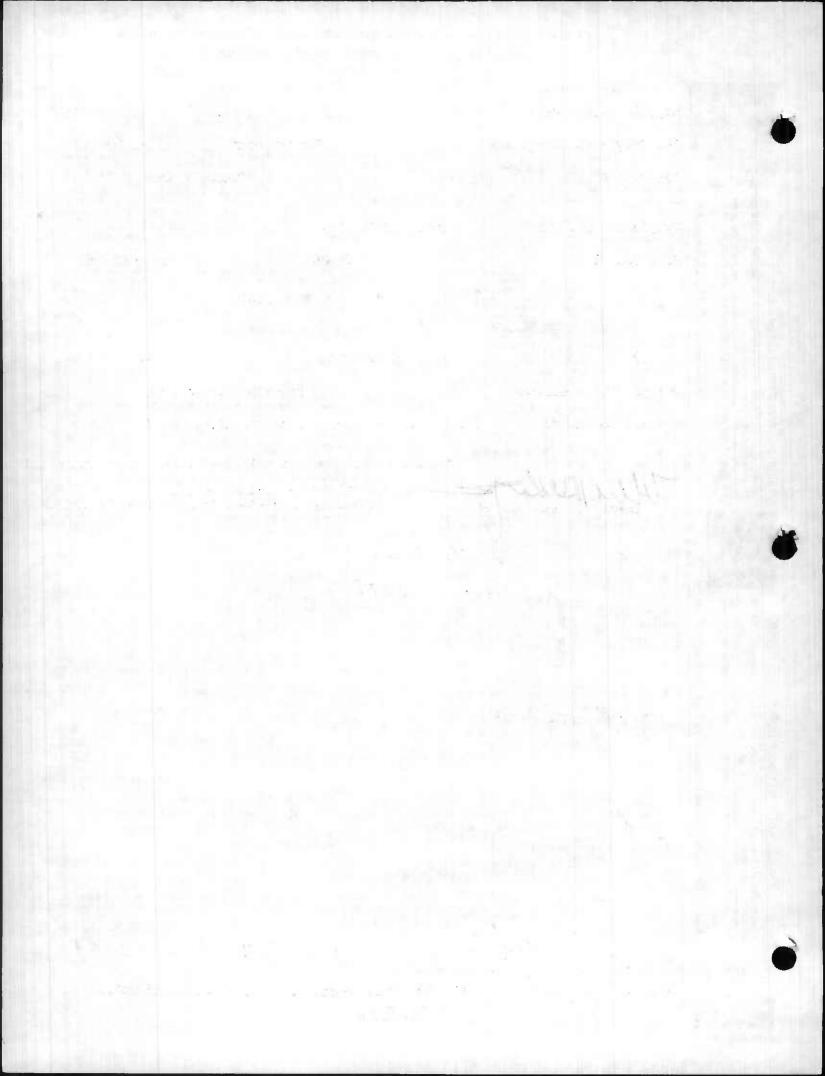
Julia Davidson Rardall

JAN 26

1998 ▶

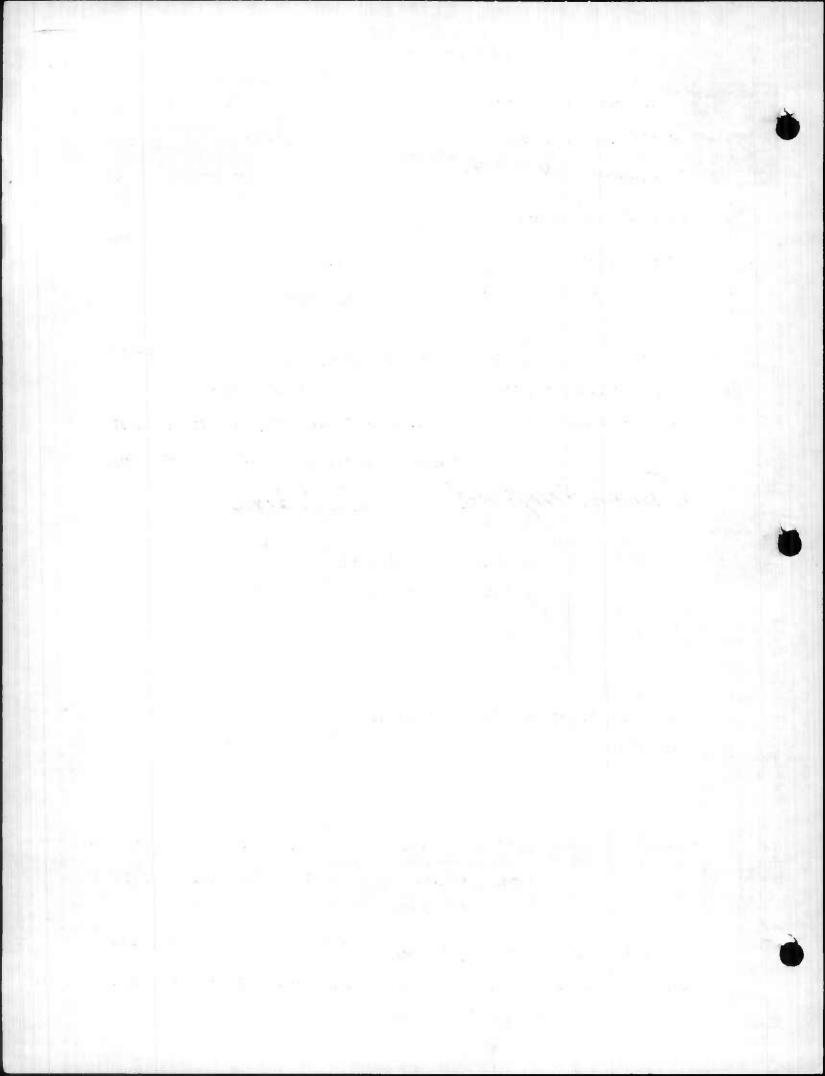
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 98 02844

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,	Physic		1. Decedent's Name (First, Midd Roland	_{le, Last)} Raffa	elle	2						2. Date of Dea Month		Year 98	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution	n, give stree	t end numi	ber)			1	4b. City, T	own, or L	ocation of Deeth		y of Death	1313
1			Peninsula R	egion	a1					Sa	lish	ury	Wi	comi	CO
	Funeral Director		5. Social Security Number 296–36–9402 Usuel Residence of Decedent	6. Sex 1₩ M		. Age (In yrs. le	st birthday) Yrs.	If Under Months	1 Year Days		Min.	8. Date of Birth (Month, De) 9-13-4	Year)	9. Birth Coul	place (Stete or Foreign ntry)
	yland		10a. State 10b. County			10c. City,	Town or Lo	cation						1	10d. Inside City Limits
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	er 10 77	Funeral Director	10e. Street and Number					10f. Zip	Code				10g. Citizen ot	Whet Cour	ntry?
	ath w	ra	20861 Warf Rd							814			US	A	
		une	11. Maritel Status	A	rmed Force		13.	Was Deced t Yes, spec	lent of city Cul	Hispanic O ban, Mexica	rigin? (Sp an, Puerto	ecify Yes or No- Rican, etc.)		ca - Americack, White,	
)20	# 5 E	by F	1 Never Married Mai	. 11	Yes 2 Yes, Give ear or Date			1□Yes 2	No	Specify	<i>/</i> :		Speci	^{fy:} Wh	ite
Maryland 21215-0020	"natural",	Pe	15. Deceder	nt's Education	n		16a. Deced	dent's Usua	I Occu	pation			16b. Kind of E		
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and	ed is o	Be	17. Father's Name (First, Middle,									e (First, Middle,	Maiden Sume	me)	
7	should be nd Mental marked o	2	Roland Cloyd									y Long			
Ma	ges 1 end 2 should t of Health end Mer If Item 27 is marke or other traumatic		19e. Intormant's Name/Relation Anne Raffaelle		'nnt)			_				el Route Numbe			Code)
ē,	Health Health em 27		20a. Method of Disposition	-/ 11110		20b. Pla	ce ot Dispo	sition (Nen	ne of		Ru.,	Bivalve	20c. Location		own. State
Baltimore,	permit. Peges 1 and 2. Department of Health er important: If Item 27 is any injury or other trau		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	3 Remo	al from St	ate	isbur	,		,		1/17/98	Salis		
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ñ	permit. Departrimporta any Inju		(Anely)	42	701	rel		Macci	ck	Funar	al H	Ome			
			23a. Part1. Enter the disease, o shock, or heart tailure. Lis	r complicatio	ns that cau	used the death.	Do not ent	Bival er the mode	ve,	MD ing, such e	z / y	or respiratory en	rest.		Approximete Interval Between
x 68760,	death certificete be executed the effect of the effect of the effect of the the effect of the effect	/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last			Due to (or a	emato	uence of): Oma uence ot):	on						
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4	The ate h	Com										1 🗆 Y	es 2 No	1[☐ Yes 2☐ No
/ita	Physician: The this certificate rai director, pag	Be	25. Was case reterred to medical examiner?								e ot Deat	h (Check only or	16)		
of	d is	70	1 X Yes 2 No 27. Manner of Death	Hospit	1 Lounp		R/Outpatien				lursing Ho	me 5 Resid			(y)
no	the Tage	Certification:	1 □ Natural 5 □ Pendi	ng 1	(Month, -13-	Day Year)	8b. Time of Injury 1800		Bc. Inju	ork?]Yes 2.5	₹No.	28d. Describe h	ow injury occu on lev		loor
Division	or Attending efter death. Director: After d in by the fune	fical	3 Suicide 6 Could	not be							2110	28f. Location (S	treet and Num		al Route Number,
5	72-6	ert	4 Homlcide	Н	building ome:	Injury - At hom , etc. (Specify) Bival	ve W	harf	Ro	oad		City or Tow Bivalv	n, Stete) e, Mar	ylar	nd
	To the Hospital of within 24 hours elements of the Funeral D completely filled it	edical (29a. Certifier (Check only one) 1☐ Certifyli 2☑ Medical	g Physician Examiner: (: To the be	est of my knowle is of examination	edge, deeth	occurred a	at the t	ime, date e	nd piece, ath occur	end due to the or red at the time, o	euse(s) and m lete and place	enner es s , and due t	eteted. to the cause(s)
	To the To the comp	M	29b. Signature and title of cartific		e Drai	Pey, M.J), DMF			se number		2	29d. Date signo 1-15		Dey, Year)
	1 2		30. Name and address of person												
	V		John T. Bulk	eley,	M.D	. 10	8 Pi	ne B	1u	ef Ro	d .	Salis	bury,	Md.	21801
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State of Maryland / Department of Health and Mental Hygiene Q

	_				Cert	ificate	of Death	7	Reg. No.	0 2.0	70
Physician		Decedent's Name (First, Middle, La:	st)					2. Dete of De Month	Day	Year 3. Time	of Deet
/Medical	ı .		Stewart					Januar			OP.N
Examiner	ď	4e. Facility Name (If not institution, give	e street and number)				4b. City, Town, o	r Location of Deat	h 4c. County	of Death	
-	4	corsica Hill				1811-1-12	Centre			n Anne	
Funeral Director		5. Social Security Number 6. S 213-22-9035 Usual Residence of Decedent	ex 7. Ag	ge (In yrs. last i 4	Dirtirious/	If Under 1 Y Months D	ear if Under 24 He ays Hours Mi		ay, Year)	9. Birthplace (Star Country) Maryland	
be notified at	-	10a. State 10b. County		10c. City, To	own or Loca	ition				10d. Inside	City Li
28a-f show notified at	5	Manual and Output Ar	200	Contr	cevill	ما				1 1 1 1 1	es 2[
28a-f	3	Maryland Queen An	ille	Gener	CVIII	10f. Zip Co	de		10g. Citizen of W	hat Country?	
23e or	5					,			USA	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
r items 23e or 28a-fe oner namt be notified Funeral Director	5	Corsica Hills C	enter	Ever In U.S.	13. Wa	21617	of Hispenic Origin?	Specify Yes or No		- American Indian	
finer D	5	1⊠ Never Merried 2 Married	12. Was Decedent Armed Forces 1 Yes 2	No			of Hispenic Origin? (Cuban, Mexicen, Pue	rto Rican, etc.)		c, White, etc.	
9 H >		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		10	JYes 2,⊠	No Specify:		Specify:	Black	
"netural", edical Ex-	3	15. Decedent's Ed	lucetion	16	Sa. Deceder	nt's Usual O	ocupetion		16b. Kind of Bu		
- 3 -	5	(Specify only highest gra			(Give kii	nd of work d NOT use re	one during most of watired)	orking			
r than	5	4th	College (1-4or	0+)	Lal	borer			State		
d other avent,		17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	, Maiden Sumeme	9)	
i merked other t umatic event, th		Alexandra Stewa	**				Janie	Royal			
M Purat		19a. Informant's Name/Relationship (15	9b. Mailing	Address (Si	reet end Number or I	-	er, City or Town, S	Stete, Zip Code)	-
27 is r treu		Winfield Henry S	Stewart(br	other)	P.0	.Box 6	7, Queent	own, Mary	land 216	58	
it of Haalth and Mantal Hygiena. If Item 27 is merked other than or other treumstic event, the M To Be Comp	1	20a. Method of Disposition		20b. Place		ion (Name o		Date	20c. Location - (City or Town, State	
Department of Important: If It eny injury or conce.		1. ■ Burlal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify				tory or other		1/0//00	0 1 - 1-	- 1 Many	1
ortan injur	-	21. Signature of Funeral Service Licen		John	Wesl	ey_UMC	hurch Cem	.1/24/98	Carmich	ael, mary.	Land
Departm Importar eny injur		21. Cignatalo di Fanoral Cottab Cicon	300				Smith Fu	neral Ho	me		
	4					P.O.Bo	x 1687, Ea	ston,Mar	yland 21		
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each li	d the death. Deine.	o not enter	the mode of	dying, such es cardi	ec or respiratory e	rrest,	Approxim Interval I	Betwee
nysician	1				0	- 1	C ,			Onset ar	10 Dea
Medical xaminer		Immediete Ceuse (Final disease or condition resulting in death)	a		re	ned	failure			30	nut
		resulting in death)		Due to (or as	e conseque	ence of):					
in end hal-trensit Examiner			b								
e attanding physicien end by for use es the bunal-trensit sician/Medical Examir	1	Sequentially list conditions, if env. leading to immediate		Due to (or as	a conseque	ence of):					
		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	C								
the the	3	that initiated events resulting in death) Last		Due to (or as	e conseque	nce of):					
ding p			d								
for use											
0 7	5 6	Part II. Other algnificant conditions co	ontributing to death b	ut not resulting	in the und	erlying caus	given in Part I.	23b. Dld	tobacco uae con	tribute to the caus	se of d
P d by		Dementin						1 🗆	Yes 2 No	3 Probably 4	Unl
		Denentra						-			
. pg D		Arthretis						24e. Wes	an autopsy ormed?	24b. Were autops available pri- completion	or to
. pg D	1									of deeth?	0, 0440
2 should be	-							1 🗆	Yes 25 No	1 ☐ Yes 1	No
2 should be	- Landing										
2 should be		25. Was case referred to medical						eath (Check only			
s certificate has been signification, page 2 should be director, page 2 should be Completed by	2	25. Was case referred to medical examiner? 1 □ Yes 2□•No	Hospital:	ent 2 ER/0	Outpatient	3□ DOA	Other	eath (Check only of Home 5 Resi	one)	er (Specify)	
this certificate has been signal director, page 2 should be	200	examiner? 1 Yes Polyno 27. Manner of Death	Hospital: 1 ☐ Inpatie 28a. Date of Inju	ry 28b	. Time of		Other: 4 Nursing	Home 5 ☐ Resi	one)		
fler this certificate has been signingeral director, page 2 should be not a To Be Completed b	200	examiner? 1 Yes PNo 27. Manner of Death Ratural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b			Other	Home 5 ☐ Resi	one) dence 6 □Othe		
fler this certificate has been signingeral director, page 2 should be not a To Be Completed b	200	examiner? 1 Yes PNo 27. Manner of Death Adatural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b	. Time of Injury	28c.	Other: Nursing	Home 5 Resi	dence 6 Other		lum ber,
fler this certificate has been signingeral director, page 2 should be not a To Be Completed b	200	examiner? 1 Yes Pool 27. Manner of Death Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	y Year) 28b	. Time of Injury	28c.	Other: Nursing	Home 5 Resi	dence 6 Other	bed	lum ber,
fler this certificate has been signingeral director, page 2 should be not a To Be Completed b	2	examiner? 1	28a. Date of Inju (Month, Da	y Year) 28b 28b 28b 28b 28b 28b 28b 28b 28b 28b	tarm, stree	28c. M it, factory, of	Other: Wursing Injury at Work? 1 Yes 2 No ice	Home 5 Resi 28d. Describe 28f. Location (City or To	dence 6 Othe how Injury occurred Street and Number with, State)	er or Rural Route N	
fler this certificate has been signingeral director, page 2 should be not a To Be Completed b		examiner? 1	28a. Date of Inju (Month, Da	y Year) 28b ury - At home, c. (Specify) of my knowled	tarm, stree	28c. M it, factory, of	Other: 4 Nursing Injury at Work? 1 Yes 2 No	Home 5 Resi 28d. Describe 28f. Location (City or To	dence 6 Othe how Injury occurred Street and Number with, State)	er or Rural Route N	
fler this certificate has been signingeral director, page 2 should be not a To Be Completed b		examiner? 1 Yes 2 No 27. Manner of Death Ratural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Exam	28a. Date of Inju (Month, Da 28e. Place of Inju building, et	y Year) 28b ury - At home, c. (Specify) of my knowled	farm, stree ge, death o	M 28c. M ccurred at the stigetion, in a 29c. Lie	Other: Vest	Home 5 Resi 28d. Describe 28f. Location (City or To	dence 6 Other how Injury occurred Street and Number win, State) cause(s) and mandate and plece, e	er or Rural Route Noner as stated. Indiducto the caus	se(s)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician					Certificate	of L	Death		Reg. No.	0	2040
	_	1. Decedent's Name (First, Middle, Las	it)		Smi	11		2. Date of De	ath Day	Yeer	3. Time of Death
/Medical	-	Anita	L.		Smil	TI		JANUA		1998	0350
Examiner	-	4e. Facility Name (If not institution, give	street and number;)		41	c. City, Town, or L	ocation of Death	4c. Cour	ty of Death	
		PENINSULA REGIONA	L MEDICAL	CENTER			SALISB	URY		WICOM	ICO
Funeral	П	5. Social Security Number 6. S	9X 7. Ag	ge (In yrs. last bi	Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v, Yea <i>r)</i>	9. Birth	plece (State or Foreigntry)
Director	1	212-72-1808 Usual Residence of Decedent		37	Yrs.			Aug.16	,1960	Mary	Land
and a	-	10e. State 10b. County		10c. City, Tov	vn or Location						I Od. Inside City Limit
Mary	ğ	Marvland Wicimic		Enand to 1	1						1⊠Yes 2□N
with the Maryland a or 28a-f show the institled at	9	Maryland Wicimic 10e. Street and Number	3	Fruitla	101. Zip C	Code			10g. Citizen o	f What Cou	ntry?
23a or	2	209 West Main S	treet		218	26			USA		
ours efter death with the Maryla all, or items 23a or 28a-f shor Examiner neat be notified at by Funeral Director	ere	11. Maritai Status	12. Was Decedent	Ever in U,S.			spenic Origin? (Sp n, Mexicen, Puerto	ecify Yes or No-		ece - Ameri	
or its		1 Never Married 2 Married	Armed Forces	? No				Rican, etc.)		lack, White,	etc.
filed within 72 hours etter Hygiene. ther than "natural", or ite ant, the wedcal Examine e Completed by Fu		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Yes 2	XI No	Specify:		Spec		ack
ed within 72 hours ygiene. ner than "naturel", nt, the Medical Exa Completed by	o le	15. Decedent's Ed (Specify only highest gra	ucetion	16e	e. Decedent's Usuel (Give kind of work life. DO NOT use	Occupa	tion	rina	16b. Kind of		
within sens.	d l	Elementary/Secondery (0-12)	College (1-4or	5+)	life. DO NOT use	retired)	any most of non	9	Salis	bury	State
filed with Hygiene rither the ent, the Com	3	12	4		Accounting				Unive	-	
tal H d out	Ď	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Sume	eme)	
2 should be filled end Mental Hygi Is marked other summatic event, To Be Co	2	Granville Tilgh				-		Roberts			
d 2 should be filed the end Mental Hyg 7 is marked other traumatic event.		19a. Informant's Name/Reletionship (7			b. Mailing Address (
C TO N L	-	Steven Smith (hu	sband)		209 West I		e Street				
W 0		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State	comoto	of Disposition (Name ery, crematory or oth	er place)	Date	20c. Location	n - City or To	own, Stete
permit. Pages Department of Important: If it any Injury or o	-	4 Donation 5 Other (Specify		Spring	g Hill Cer		ry 1	/26/98	Salis	bury,	Md.
pemit. Departrimports any Inju		21. Signature of Tuning Service Licen	59 /		22. Name and		s of Facility ith Fune	ral Hom			
20 = 0 0		* Xem 76. 4	Juna		P. O. B	0×1	687. Eas	ton. Ma	rvland		
		Part Enter the disease, or compand for heart failure. List only of	lications that ceuse one cause on each li	d the death. Do ine.	not enter the mode	of dying	, such as cerdiac	or respiratory as	rest,		Approximete Interval Between
Physician	1			, , -	0 1	1	111	/			Onset and Death
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Meta.	static	Relai	(c// (arke	1		6 mos
		resulting in death)		Due to (or es e	consequence of):					(
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icate be executed physician end s the buriel-transit	Y	Sequentially list conditions,		Due to (or as a							
be e burician		if any, leading to immediate			consequence of):						
	_	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated execute.	c								
ficate physicate is the	_	if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C	Due to (or as a	consequence of):						
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AND SERVICE

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** JANET TILMAN STARKEY 98 10:17 Pm /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Denton Caroline Nursing Home, Inc. Caroline H Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. APR . 14, 1920 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** 10 M 25F 77 Yrs INDIANA Director 578-16-4651 Usual Residence of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at TALBOT

10e. Street end Number 1 ☐ Yes 2 No EASTON 10f. Zip Code 10g. Citizan of What Country? 6892 TRAVELERS REST CIRCLE 21601 U.S. deeth. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours efter Department of Healith and Mental Hygiens. Important: If Item 27 is marked other than "natural", or the any injury or other traumatic event, the Madical Examina 1 Yas 2 No If Yes, Giva Yeer or Dates: 1 ☐ Never Memied 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No WHITE Specify: à 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 4 LIBRARY ASSISTANT LIBRARY 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be CARL GREAR TILMAN HELEN GREEN 19e. informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CARLA G. STARKEY -DAUGHTER P.O. BOX 42 EASTON, MARYLAND 21601 20b. Plece of Disposition (Nema of cemetary, crametory or other place) 20e, Method of Disposition Dete 20c. Location - City or Town, Steta 1 ☐ Burial 2 X Cremation 3 ☐ Removel from Steta 4 ☐ Donation 5 ☐ Othar (Spacify) CHES. CREM. CTR. 1-19-98 CHESTER, MARYLAND 21. Signatura of Funerel Service Licensee 22. Name end Addrass of Facility
FELLOWS, HELFENBEIN & NEWNAM 23a. Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiec or respiretory errest, shock, or heert feiture. List only one cause on each line. EASTON, MD. 21601 Approximete Intervel Between Onsat and Death Physician 5 days Immediate Cause (Final disaasa or condition resulting in deeth) Uro sepsis /Medical Examiner Due to (or es a consequence of): Examiner 109001 Dementia g physician and es the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Division of Vitai Records, P.O. Box 68760, Physician/Medical Due to (or es e consequança of): ettending p signed by the et id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown þ should should 24b. Wera eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed has page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Attending Physician: funeral director, 25. Wes case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred After 1 Neturel 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No a Hospital or Attendi 24 hours efter death Funeral Director: / 2 Accident filled in by the 3 Sulcide 6 Could not be determined Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital
within 24 hours e
To the Funeral C 1 Cartifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29b. Signatura and titla of certifier 29c. Licensa number 29d. Deta signed (Month, Dey, Year) algo D0051132 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) DAFFIN LANE JORGE H. ABREGO, M.D. DENTON, MD. 21629 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State Julia Savidson-Randale

DHMH 16 Rev 6/95

Registrar

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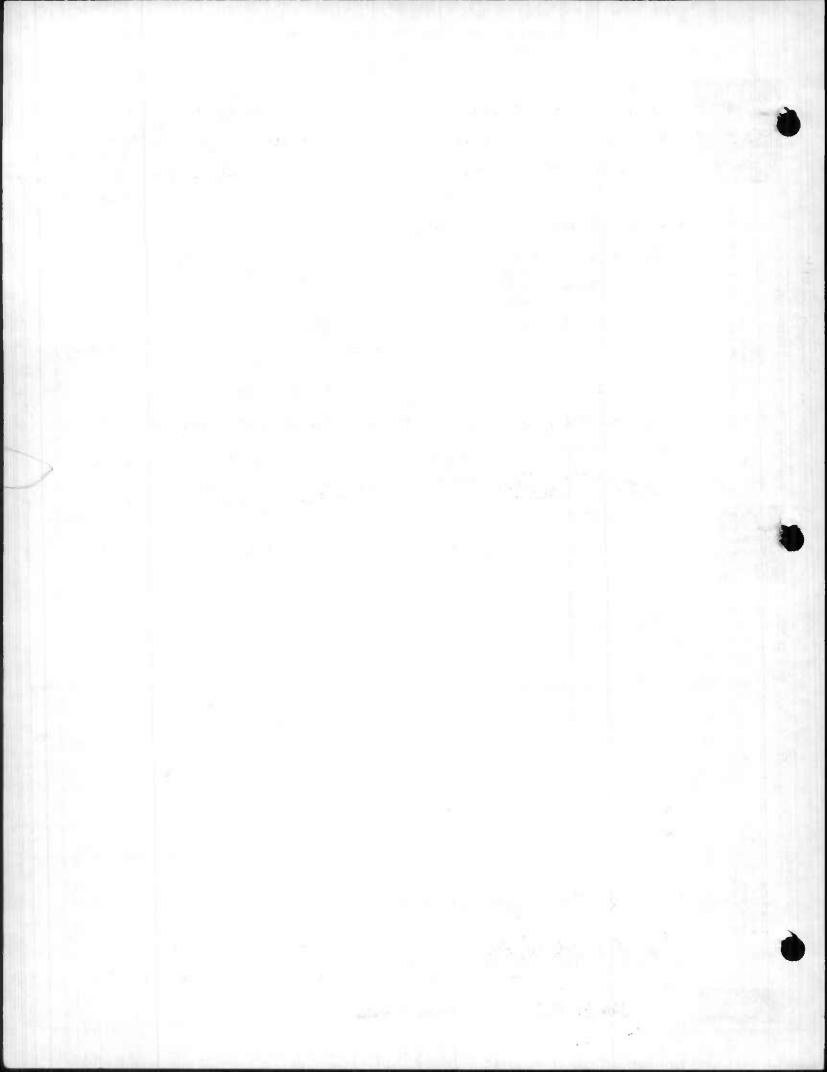
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State of Maryland / Department of Health and Mental Hygiene 98 02848

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	Memorial Hos	pital @ Ea	aston		Eas	ston		Talbo	ot
eral ctor	5. Social Security Number 6. Se	7. Age (In ☐ M 2X☐ F	yrs. last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs.	8. Date of Bir (Month, De 4/5/19	rth ey, Yee <i>r)</i> 20	9. Birthpla Counti Mary 1	ace (Stete or Foreig ry) Land
3	10a. Stete 10b. County	100	c. City, Town or Lo	cation				10	d. Inside City Limits
Director	Maryland Talbot		Claiborne						1 ☐ Yes 2 🖾 No
Dir.	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
era le	23337 Tunis Lane	10 Wes Based of East	5-110	21624	411	16.16	USA		
any injury or other traumatic evant, the Medical Examinet, must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Yes, specify Cul	Hispanic Origin? (Spo ben, Mexican, Puerto Specify:	ecity Yes or No Ricen, etc.)	Specif	e - Americe ck, White, e v: Black	tc.
Completed	15. Decedent's Edu	ucetion	16a. Deced	ent's Usual Occu	petion		16b. Kind of B		
n Die	(Specify only highest green Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retin	e during most of works ed)	ing			
5	8th		Dome	estic			Domest	ic	
Be	17. Fether's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle	, Maiden Suman	ne)	
2	Stephen Trott				Reida Go	oslin			
E	19a. Informant's Name/Relationship (T)	/pe, Print)			et end Number or Rure				
	Kennard Smith (s				Ln. (P.O.Bo	ox 52)	Claibor	ne,Md.	.21624
10 10	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F		b. Place of Dispos cemetery, crem	sition (Neme of netory or other pla	ece)	Dete	20c. Location	City or Tow	n, State
6	4 ☐ Donation 5 ☐ Other (Specify,		Claiborn	e Cemet	ery 1	/10/98	Claibor	ne,Mar	cyland
any in	21. Signature of Funeral Service Ligens		22	Name and Addr Bennie S	ess of Facility	eral H	ome ryland	21601	
	23a. Part 1 Enter the disease, or comp shoot, or heart failure. List only o	lications that ceused the d					-		Approximete
ian	snow, or near failure. List only o	ne cause on each line.							Intervel Between Onset end Death
cai	Immediate Cause (Final disease or condition	Pnew	monie						, will
ner	resulting in death)	a. Due t	to (or as a conseq	uence of):				1	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ne			(5) 40 4 55,1554	201100 017.				1	
ami	Sequentially list conditions,	b. — Due t	to (or as a conseq	uence of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							i	
1 473	that initiated events resulting in death) Last	C. Due f	o (or es e consequ	ience of):					
~ ~		d							
by Physician/	Part II. Other eignificant conditione co	ntributing to death but not	resulting in the un	derlying cause g	iven In Part I.	23b. Did	tobecco use co	ntribute to 1	the cause of deeth
y Physic	Oulite house	anhor com		.18.	lant	10	Yes 2 No	3 Proba	ably 4 Unknow
p A	District I am		7 00	XLSTI-					
	Failure CAPY	o clama	re rend	G. lim		24a. Wes	en autopsy omed?	evai	e eutopsy findings lable prior fo
Completed	, , ,	, 0000	-	12110				of de	pletion of cause eath?
To Be Compl	upper Gastron	ntestimal 51	red			1 🗆	Yes 20 No	10	Yes 2□ No
Be C	25. Was case referred to medical				26. Place of Death	(Check only	one)		
To	examiner? 1 ☐ Yes 2 No	lospital:	2 ☐ ER/Outpatient	3□ DOA O	ther:		dence 6 □Oth	er (Specify)	
	27. Manner of Death 1 DtNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		28c. Inju			how Injury occur		
ertific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, streecify)	et, factory, office		28f. Location (City or To	Street and Numb wn, State)	per or Rural	Route Number,
Medical Certifi	29a. Certifier (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the t estigetion, in my	ime, date end place, a opinion, death occurr	and due to the ed at the time,	cause(s) and madate and piece,	anner as sta end due fo t	ited. the ceuse(s)
Me Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signe		ey, Yeer)
	1 / SX / () K	mm	Street,	030	7749		1/8/9	8	
	30. Name and address of person who co				7	1 3	21601		
State		32. Registrar's S	ignature		easton, Ma	ryland	21001		
State		98 Auhia	Davidne 1	and an					
		MD ,503 Dut	chman's	Print) Lane_, I	. , .	ryland			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year Jan. 13, CORNELIUS 10:50 p.m. ALLER SHERWAN 1998 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4876 Barneck Rd. Ti lghman Talbot 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 13, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1**X**3 M 2□ F Deys Hours Yrs. 155-10-9888 1915 Penna. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Talbot Tilghman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4876 Barneck Rd. 21671 U.S.A. 12. Was Decedent Ever in U,S.
Armed Forces?

12 Yes 2 No U.S.
If Yes, Give
Year or Dates: Army Ret 11 Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Major Retired U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Fletcher Sherman Myrtle Aller 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife June Kaiser Sherman 4876 Barneck Rd. Tilghman, Maryland 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Plece of Disposition (Name of cemetery, crematory or other place) Jan. 16 ate 1998 oc. Location - City or Town, State Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hurlock Maryland Eastern Shore
22. Name and Address of Facility 21. Signature of Funeral Service Licenses Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663

23a. Part 1. Enter the disease, or complications that closed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer with metastasis 199 Due to (or as e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

physician end s the burief-transit

98

signed by to

been sig

certificate

this

nours efter death.

neral Director: After this y filled in by the funeral di

To the Hospital within 24 hours e To the Funeral C completely filled

Hospital or Attending Physician: 24 hours efter death.

pege 2 s has

by

Completed

Be

Certification: To

Medical

The law requires that the death certificete be executed

Box 68760.

P.O. 1

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23a or 28a-1 show the Medical Examiner must be nothing at

Director

Funeral

by

Completed

Be

the Marylend

filed within 72 hours efter

Hygiene.

Pages 1 end 2 should be nent of Health end Mentel int: If item 27 is marked or

other

permit. Page Depertment of Important: If any Injury or once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

4 Homicide

25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28d. Describe how Injury occurred

28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

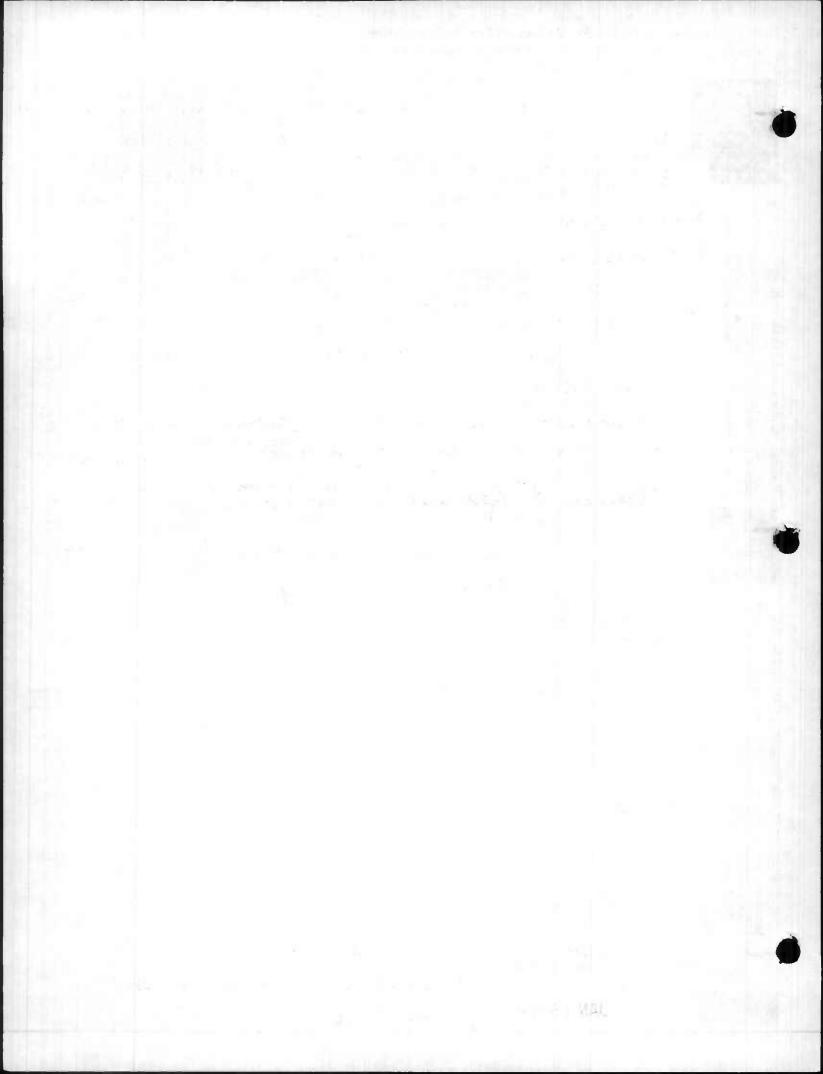
D46020 SOM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

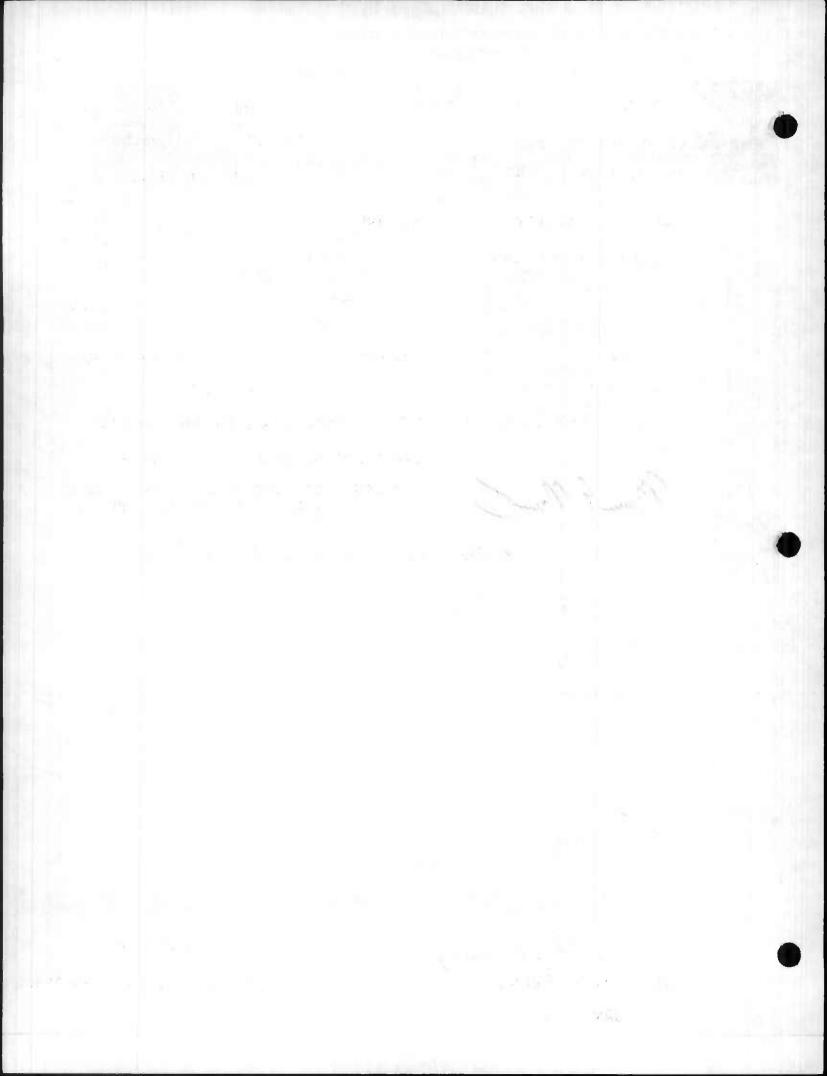
Syed I. Ali M.D. 506 Idlewild Ave. Easton, Maryland 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

JAN 1 5 1998 Gulia Davidson

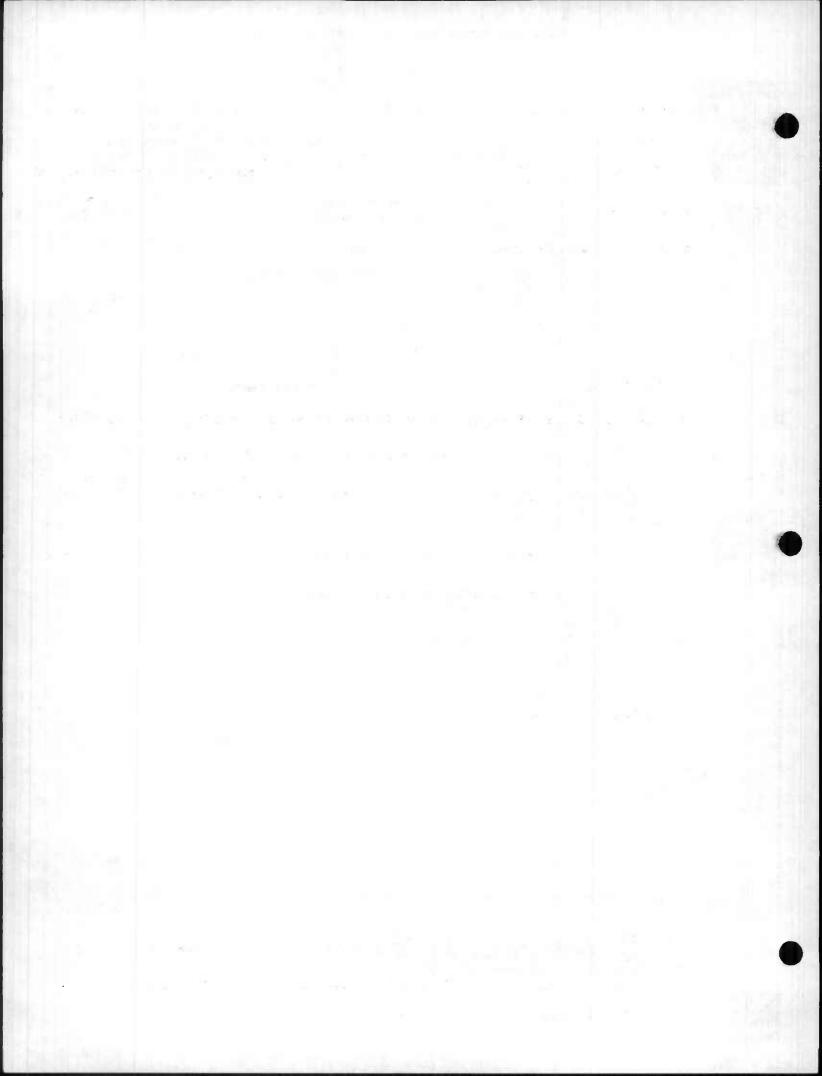


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000	resulting in death) Sequentielly list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Dissess or Injury that initiated evants rasulting in death) Lest	e. #//// b	Due to (or as	s a conseq	uence of): uence of):	die vaser,	lar di	(MAIC	<i>m</i>	アベーンハン
= £ >	Part II. Other significant conditio	d	but not resulting	ng in the ur	nderlying causa gi	iven in Pert I.	23b. Did	tobacco use con	ntribute to the	e cause of dea
be detected by Physical Physic							10	Yes 2□ No	3 Probabl	ly 4 ☐ Unkn
2 should								an eutopsy ormad?	eveilat	autopsy finding ble prior to letion of cause hth?
Pege Com							1 🗆	Yes 2 No	1 □ Ya	as 2ETNo
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00	1 Yes 2 No	Hospitei: 1 ☐ Inpati	tient 2 ER	/Outpetien	t 3 DOA Ot	thar: 4 Nursing H	tome 5 Resi	dance 6 Othe	er (Specify)	
≠ 8	27. Manne of Daath 1 Naturel 5 Panding 2 Accident investig	ation	jury 28 Pa <i>y Year)</i>	b. Tima ot Injury	Wo		1	how injury occurre		
Director: d in by the	3 Suicide 6 Could n 4 Homicida datermi	ined 286. Piece of in	njury - At home atc. <i>(Specify)</i>	, farm, stra	ael, factory, office		28f. Location (City or To	Street and Numbe wn, Stata)	er or Rural Ro	oute Number,
Funer Funer stely fill	29a. Certifiar (Check only one) 1 Certifying 2 Medical E	g Physician: To the best Examinar: On the basis of and manner s	of examination	dge, deeth and/or inv	occurred et the ti rastigation, in my	ime, date end place opinion, deeth occu	a, and due to the urred et the lime,	cause(s) end med date end place, e	nner es stete end due to the	d. e ceuse(s)
	29b. Signature and title of certifier 30. Name and address of person v	25 Chel	death (they are	la) (Time	29c. Licani D314			29d. Date signed	Month, Day	Year)
State		LSEDER, I		.D.,		OUTCHMAN	'S LAN	E, EAS	TON, I	MD 216



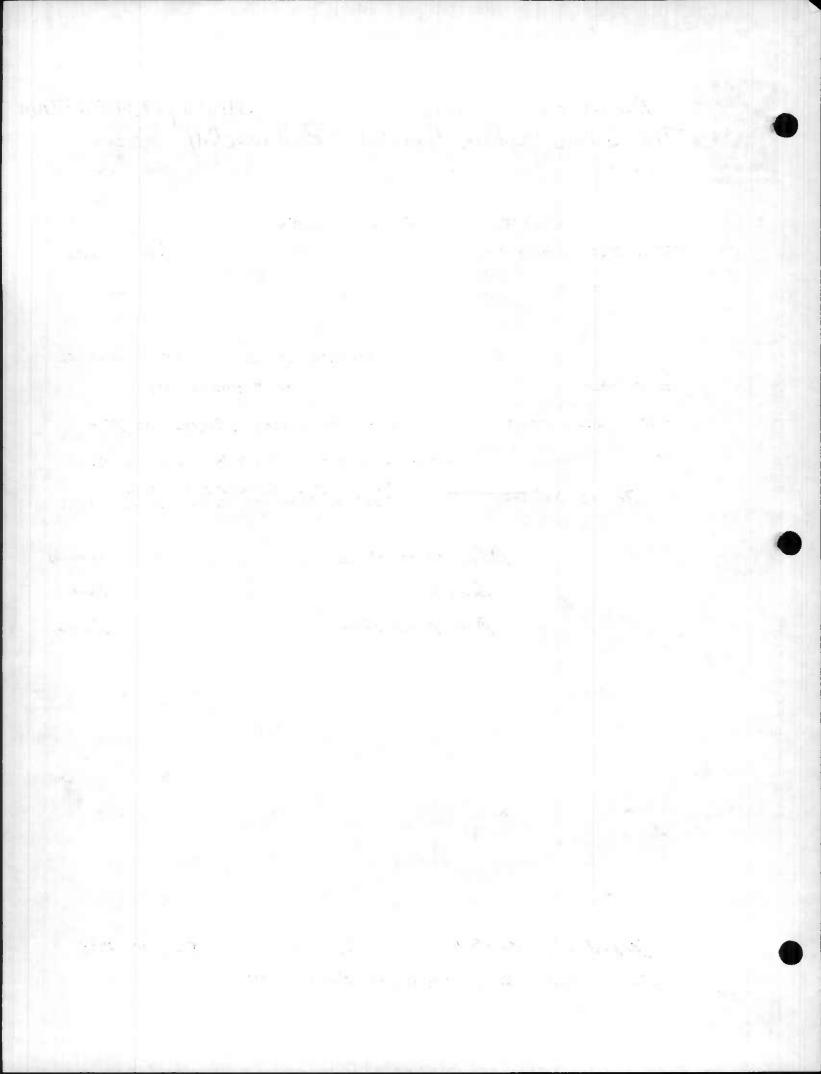
State of Maryland / Department of Health and Mental Hygiene Q

Physician	_	1. Decedent's Neme (First, Middle, Las	<i>t</i>)	1	913	100				2. Dete of D		Dey	Yeer	3. Time of	Deeth
Medical/	_	Ruth Natio	ons		S	chen	ck					1998	1001	9:454	AM
Examiner	-	4e. Facility Neme (If not institution, give	street end nu	mber)				4	b. City, Town, o	r Location of Dec	eth	4c. County	of Death		
	4	Manor Care							hevy Cl				gomery		
ineral rector	1	777 30-3030	ex □M 24© F	7. Age (I 86	in yrs. lest	Yrs.	If Under 1 \ Months D	ear ays	If Under 24 H Hours Mi		10 ,	1911	9. Birthple County Flat R	oce (State o V) (iver,	r Forei
*_	- 1-	Usual Residence of Decedent 10a. State 10b. County		10	Oc. City, To	wn or Lo	cation					-	10	d. Inside Ci	ity Limi
be notified a		D.C. N/A					n, D.C.							Yes Yes	*
23a or 2		10e. Street end Number 5206 Manning Place	N.W	•			10f. Zip Co					Citizen of W	Vhet Count	ry?	
Item 27 is marked other than "netural", or items 23s or 28s-f show other traumstic event, the Medical Exeminer must be notified at To Be Completed by Funeral Director	2	11. Maritel Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Dec Armed Fo 1 Tes it Yes, Gir Yeer or D	orces? 2 X No	er In U,S.		Vas Decedent f Yes, specify I □ Yes 2x		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	lo-	Blac	e - Americe k, White, e White	tc.	
r, the Medical		15. Decedent's Ed (Specify only highest great	ucetion de completed)		16	(Give	lent's Usual O kind of work o	lone a	uring most of w	rorking	16b	. Kind of Bu	siness/Indu	ustry	
mp		Elementary/Secondary (0-12)	College (1-4or 5+)			OO NOT use r	etired,			La				
office Co		17. Father's Name (First, Middle, Last)	4		A	ttori	iey		18. Mother's N	ame (First, Middl	-		e)		
arked out	5	Heber Nations							Mattie		,		-/		
umati		19a. Intorment's Neme/Relationship (7	ype, Print)		1	9b. Mailin	g Address (S			Rural Route Num	ber, Ci	ty or Town,	Stete, Zip (Code)	
item 27 is marked other than other traumatic event, the M. To Be Comp		Herbert H. Schenc	k Husl	band	5	206 N	lanning	g P	lace, N	W, Washi	ngt	on, D	. C.	20016	,
unt: If item ury or other	1	20a. Method ot Disposition 1 ☐ Burial 2 🛎 Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Ctata	ceme	tery, cren	sition (Name netory or othe afort C	r plece		Date 1/22/98		. Location -			
Important: If it any injury or o		21. Signature of Funeral Service Licen	11/10	_						loseph G					
sician		23a. Pervi , Enter the disease, or comp shoot, or heert tailure. List only o	licetions that one ceuse on e	caused the each line.	e death. D	o not ente	er the mode o	t dying	g, such as cerd	ac or respiretory	errest,		104	Approximete Intervel Bety Onset end [ween
edical miner	- 1	Immediete Cause (Final disease or condition resulting in death)	Acute	e Myo	cardi	ial l	Infarct	:101	ı				1	5Minu	tes
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g physicia as the bur Tedical		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest	С	Due	e to (or es	e consequ	uence of):								
for use			d												
datached f		Pert II. Other eignificant conditions co	ntributing to d	eath but n	ot resulting	In the ur	derlying cous	e give	n in Part i.			co use con			
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2 should										24e. Wa	s en e		com	re eutopsy fi ileble prior to apletion ot co eeth?	0
page Com										1 🗆	Yes	2X No	1 🗆	Yes 2□	No
director, par		25. Was cese referred to medical exeminer?							26. Piece of D	eeth (Check only	one)				
er this eral di		1 ☐ Yes 2 🛣 No 27. Menner of Deeth 1 📆 Neturel 5 ☐ Pending	28e. Date	-	2 □ ER/0 ear) 28b	Outpetien Time of Injury	28c.	Othe Injury Work	et ?	Home 5 Res					
To the Funeral Director: After to completely filled in by the funeral Medical Certification:		2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece buildi	of Injury ing, etc. (S	- At home, Specify)	term, stre	M eet, tactory, of		es 2□No	28f. Location City or T	(Stree own, S	t end Numbe tete)	er or Rural	Route Num	ber,
mpletaly filled		29a. Certifier (Check only one) 1	iner: On the b	best of masis of exa	aminetion e	ge, deeth end/or inv	occurred et ti estigetion, in	he tim my op	e, dete end ple inion, deeth oc	ce, end due to the curred et the time	e cause , dete	e(s) end me end place, e	nner es ste and due to t	ited. the cause(s)
ompl Me	1	29b. Signature and title of certifies	- 11	nor dialoc	Λ		29c. Li	cense	number		29d.	Date signed	i (Month, D	ley, Year)	
- 0		1 () heel	2/50.		allo	h	D1	318	37		Jan	uary	19. 1	998	
		30. Neme and eddress of person who c	ompleted cous	se of death	(Item 200	(Type.	0				JUL	y	, L	,,,,	
	1	Neill Kennedy M			//		in Ave.		Charry	Chase, M	m ^	00015			



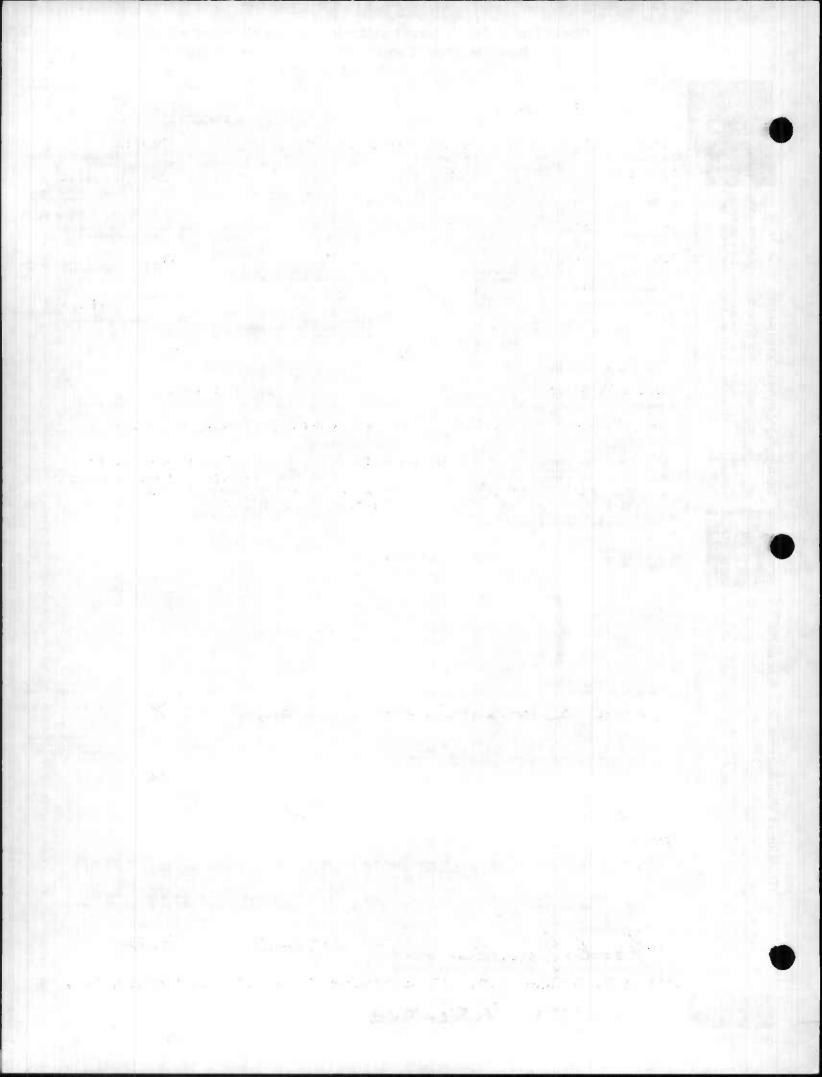
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Physiciar /Medica Examine	n il		Pozier 5	idbu	y	4b. Gity, Town, or L	Janu	1ary 19	3. Time of Death
LAGITITIE		The Johns	5 HOPKIY	ns t	tospita	Baltin	pore Ci	LA	ltimore
Funeral Director		5. Social Security Number 213–58–8219 Usual Residence of Decedent	Sax 7. Ag	e (In yrs. le 46	Yrs. If Un Month	der 1 Yaar If Under 24 Hrs. Deys Hours Min.	8. Date of B (Month, D NOV • 2	irth ay, Year)	Birthpiace (State or Foreig Country) DC
show		10a. Stata 10b. County		10c. City	Town or Location				10d. Inside City Limits
the Maryle	o c	MD Prin	ce George			Springdale			1 Styles 2 □ No
death with the Marylend rms 23e or 28a-f show	a Dire	10e. Street and Number 9501 Ardwick Ar	dmore Road		10f.	Zip Code 20774		10g. Citizen of \Unit	Whet Country? ed States
al', or its	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yas 2 ☑ 1 If Yes, Give Year or Datas:			cedent of Hispanic Origin? (Specify Cuban, Mexicen, Puerto	pecify Yas or N Rican, etc.)	o- 14. Rac Blac Specify	e - Americen Indien, ck, White, etc.
within ane.	ompleted	15. Decedent's (Specify only highest Elementery/Secondary (0-12)	Education grade completed) College (1-4or 5	5+)	life. DO NO	work done during most of work rusa ratired)			usinass/Industry
other vent, le	3	17. Fether's Nema (First, Middle, La			A	ccounts Manage	er ne (First, Middle	a, Maiden Suman	e Industry
s 1 and 2 should be filed f Heelth and Mental Hyg Item 27 is merked other other trsumstic event,	0	Laster Rozier				Mary F	Katheri	ne Hill	
and No.		19a. Informant's Neme/Ralationship	(Type, Print)		19b. Mailing Addre	ess (Street and Number or Ru			State, Zip Code)
of Heelth of Hee		David Sidbury -	Husband		9501 Ar	dwick Ardmore,	Sprine	dale, M	D 20774
		20a. Method of Disposition 1 Buriai 2 Cremetion 3 4 Donetion 5 Othar (Spe			aca of Disposition (I metery, crematory of orge Wash	Vame of or other place)	Date /24/98	20c. Location -	City or Town, State hi, MD
permit. Page Depertment of Important: If any injury or once.		21. Signature of Funerei Sarvica Lic	forton		R. I	end Address of Fecility N. Horton Co. Kennedy Stree	Mortic:	ians, In	c.
ifficate be executed g physician end as the buriet-transit	legical Examinier	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in deeth) Last	o	Due to (or	es e consequence d	or):			G meaths / year 2 works
requires that the death certienen signed by the ettendin hould be detached for use	Carve	Part II. Other significant conditions	d.	ut pot rocul	tion in the underlyin	a course share in Post I	225 Die		
thet the led by the detache		ath. One agmicant condition	CONTIDUTING TO COULT DE	ut not resur	ang in the underlyin	g cause given in Pert I.		Yes 2 No	ntribute to the cause of death
200	ולופופת מ						24e. We	s an autopsy ormed?	24b. Wara autopsy findings available prior to completion of cause of deeth?
The lew page 2 si	5						10	Yes 2 No	1 ☐ Yes 2 No
clan: sertific ector.	מ	25. Was casa rafarred to medical axaminer?	Magnitule			26. Pleca of Dea	th (Check only	one)	
To the Hospital or Attanding Physician: The lew within 24 hours effect deeth. To the Funerel Director: Affer this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comm		1 Yes No 27. Menner of Deeth 1 Naturel 5 Panding 2 Accident investigat	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day		R/Outpetient 3 D 28b. Time of Injury M	DOA Other: 4 Nursing H		idence 6 Oth how injury occur	
To the Hospital or Attanding P within 24 hours effer deeth. To the Funerel Director: Affer t completely filled in by the funer. Medical Certification:		3 ☐ Suicide 6 ☐ Could not determine	28a. Place of Injubuilding, etc	ury - At hon c. (Specify)	ne, ferm, street, fact	ory, office	28f. Location City or To	(Streat and Numb wn, State)	er or Rural Route Number,
To the Hospital or within 24 hours effe to the Funerel Dir completely filled in Medical Cert	Colical	29a. Certifiar (Check only one) 12 Certifying 12 Medical Ex	Physicien: To the best of aminer: On the basis of and menner ste	examinetic	ledga, death occurre on and/or investigati	ed at the time, date end plece, on, in my opinion, death occur	end due to the red et the time	ceusa(s) and ma date end place,	anner as steted. end due to the causa(s)
Withir comp		29b. Signature end title of certifier				29c. Licanse number		29d. Date signe	d (Month, Day, Year)
1		Claules . D. S.	Drake M.D./P.	h.D.	29a) (Tuna Print)	RES-000 Bultimux, Me		Janury 1	9, 1998
		Charles G. Dr	ake, Juhn	Hypk (15 1-Nspihl	, Bultimus, Me	0	•	
State Registrar		31. Data filed (Month, Day, Year)	32. Registre	ers Signatu	ire				



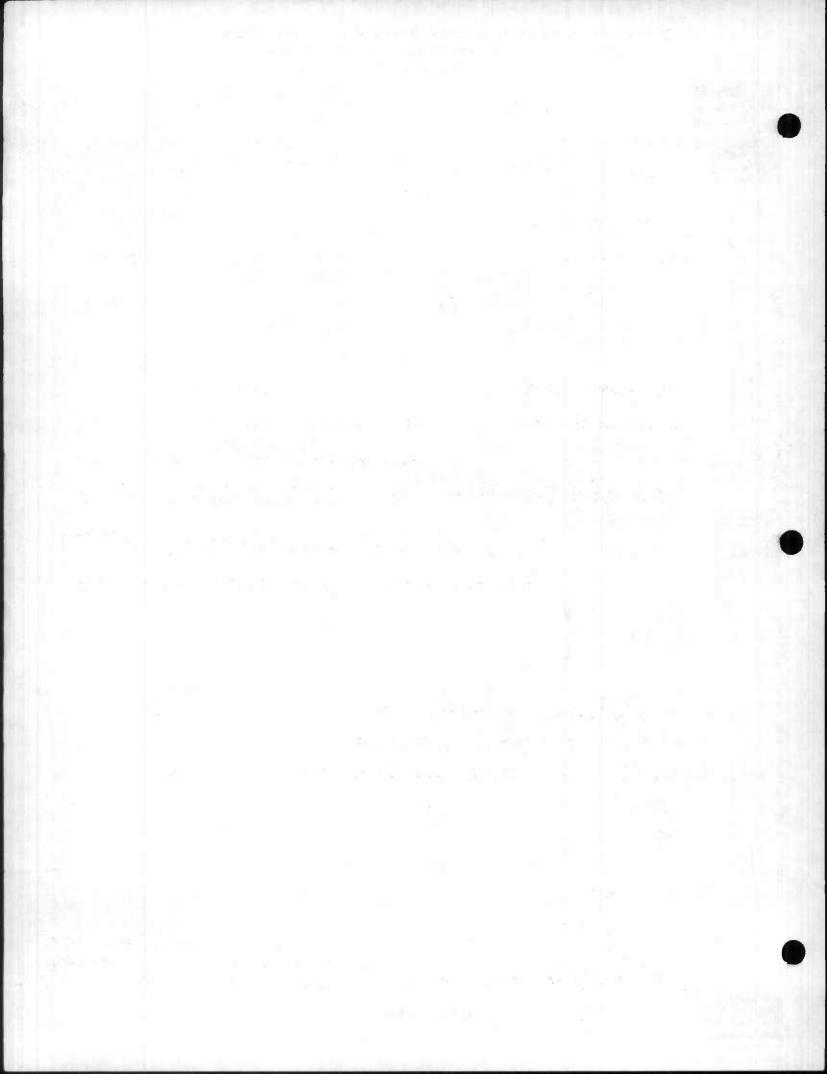
State of Maryland / Department of Health and Mental Hygiene 8 0 2 8 5 4

Due to (or as a consequence of): Due to				C	ertifica	te of	Death	R	eg. No.	06	_004
William V. Stoos, Jr. Carroll Lutheran Village Health Care Ctr. See Step Waser (for States) pass repeated annuable of the Company of the Campany of the Ca	•	1. Decedent's Name (First, Middle, Last)			H		2. Dete of Dee	th		3. Time of Dea
Station Service (free controlled part of the state of the service) Service Court of Death Courty of Death Carry 11 Service Courty of Death Courty of Death Carry 11 Service Courty of Death Se	•	William V. St	oos, Jr.					_	7 17, 1		8:50 H
CATYOLI LUCINETY NILINGE Health. Care Ctr. Meximum Front Month Mex							4b. City, Town, or L		1		
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215-05-1052 215-0	Funeral				ay) If Unde	er 1 Year	If Under 24 Hrs.	8. Date of Birth)		place (Stete or Fo
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Salver Spring	of Ha	· ·		20b. Plece of D	sposition (Ne	ome of	ce)		20c. Location	- City or To	own, State
Salver Spring	Page ent of ry or		dellioval irolli State				1	/22/98 F	Baltimo	re. M	iD
Salver Spring	nit.										
23a. Part. Enter the disease, or complications habsfulsed the death. Do not enter the mode of dying, such as cardiac or respiretory errest, intervel Barwenn (Need lead Examiner) Manual Part	Deg and a grad	1 William.	I Byr	0	Home,	Inc	. 500 Un	iversity			
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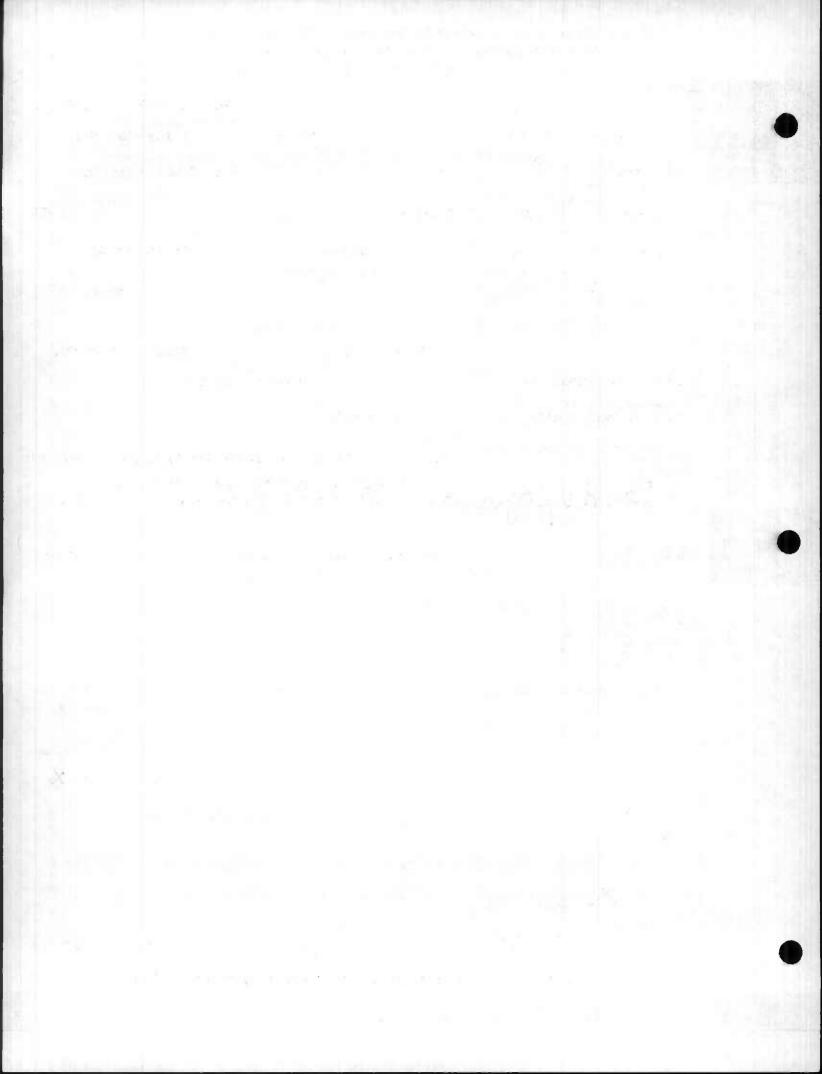
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					Certifica	te of	Death	Re	g. No.	U L	2855
Dhuei	-1	1. Decedent's Nama (First, Middle, Li	ast)	-				2. Data of Death Month	Day	Yaar	3. Tim U D th
Physic /Med		Thomas Gene St	umrell					January			11:35 M
Exam		4a. Facility Nama (If not institution, gi	va street and number)			4b. City, Town, or Lo	cation of Death	4c. County	of Death	-
		Suburban Hospita	a1				Bethesd	а	Mor	ntgom	erv
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ilan:	Be	25. Was casa raferred to medical examiner?					26. Place of Deat	(Check only one)		
Physic this ce ral dire	2	1 Yas 2 No	Hospital: 1 Inpati	ant 20 ER/OL	utpatient 3 C	OA Ot	har: 4 Nursing Ho	ma 5 🗆 Rasidar	ice 6 Oth	nar (Specif	(v)
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for Attending Physician: The law requires tefer deeth. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 ☐ Suicida 6 ☐ Could not be datermined	28a. Place of In	jury - At homa, fa lc. (Spacify)	arm, straat, facto	ry, offica		28f. Location (Stra City or Town,	aat and Numt Stata)	ber or Rura	al Routa Number,
To the Hospital or Attending Physician: The I within 24 hours efter deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Cartifiar (Check only one)	nysician: To the best niner: On the basis o and manner st	f examination an	a, death occurred d/or invastigatio	d et tha ti	ma, data and place, opinion, daath occurr	and dua to tha cau ed at tha tima, da	usa(s) and mata and place,	anner as s	tetad. o tha ceusa(s)
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		30. Name and address of person who	completed cause of	teath (Item 23e)	(Type, Print) //	120	> 1000	KVI	CUE	1	STICE
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fedic:		Edward W.	Swann	, Jr.				Jan. 1	.7, ^D 1998	Yeer 1	:30P.m.
amine	_	4e. Fecility Name (If not institution, given 1721 Crofton Pa.		May.			4b. City, Town, or Crofton	Location of Deet		of Deeth Arund	el
eral ctor		911 00-3331	Sex. 7. Age	(In yrs. lest	Yrs. If Und Month	er 1 Year s Deys	If Under 24 Hrs Hours Min.	8. Dete of Bir (Month, De March	31,1950	9. Birthpleco Country) Mary La	e (Stete or Foreig and
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	to	Maryland Anne Ar	unde1	Crof							1 □ Yes 2
	ai Director	10e. Street end Number 1721 Crofton Pa	rkway			Cip Code			10g. Citizen of V United		
	by Funeral	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XXVIII If Yes, Give Yeer or Dates:	ver in U,S.		edeni of Hecify Cuba 2XXIo	lispenic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	14. Rec Ble Specifi	ce - American ck, White, etc. Whit	
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		17. Fether's Name (First, Middle, Last))		vice Fie	STUEL		ne (First, Middle,	Econom	•	s co.
	To Be	Edward W. Swann,	Sr.				Frances	Cusi	ck		
		19e. Informent's Neme/Relationship (Beth T. Swann (wi			19b. Mailing Addre		end Number or Ri	urel Route Numb	er, City or Town,	Stete, Zip Co	ode)
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pleisify filled in by the funeral director, pege 2 should be deteched for use as the buner-transit	ledical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underflying Cause (Disease or Injury the initiated events resulting in deeth) Lesi Pert II. Other significant conditions of Cause (Disease or Injury the initiated events resulting in deeth) Lesi Pert II. Other significant conditions of Cause (Cause of Cause D c. D d	Due to (or es	s e consequence of se conseque	DOA Other	en in Pert I. 26. Plece of Deer: 4 Nursing H k? Yes 2 No ne, dete end plece ptnlon, death occu	23b. Did 1 24a. Wes performence of the second of the sec	Yes 2 No en eutopsy primed? Yes 2 No one) denca 6 Ott how Injury occur Street end Number, Stete) ceuse(s) end mudete end plece, 29d. Date signe	ntribute to the 3 Probab 24b. Were eveiled complication of dee 1 Year (Specify) red per or Rurel Reference as stelle end due to the	e cause of death y 4 Unknown eutopsy findings ble prior to teltion of cause th? es 2 No oute Number, d. e cause(s)	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Deeth **Physician** Month 6:15 AM ALBERT WEEMS SUITT Samugra 18 1998 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** ARUNDEL HOSPITAL GLEN BURNIE Anns HRUMOEL ORTH 6. Sex 1**XX**M 2□ F If Under 1 Year | If Under 24 Hrs. 5. Social Securify Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dev. Yeer) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. Director 6-7-1923 MARYLAND 216-16-1258 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ahow r 28a-f ahow 10d. Inside City Limits Director 1 ☐ Yes 2√2 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? rai', or items 23a or 21061 191 C VIRGINIA LANE U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Amed Forces? 1 ঐ Yes 2 □ No If Yes, Give Yeer or Dates: 1941-47 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, efc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important If item 27 is marked other than "natur any injury or other traumetic event, the Medical 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION PLUMBER Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be EDWARD WEEMS SUITT ANNA BELKE D. 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 313 MAGOTHY BRIDGE RD. PASADENA, MARYLAND 21122 SANDRA RILEY DAUGHTER Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20s. Method of Disposition Dete 20c. Location - City or Town, State 1 □ Buriat 2 ☐ Cremation 3 □ Removal from State on 5 Other (Specify) 4 Donak CHESAPEAKE CREMATORY INC, 1-19-1998 BELTSVILLE, MARYLAND t Funeral S 22. Neme end Address of Facility SINGLETON FUNERAL HOME, P.A. Kade 1 SECOND AVE.S.W. GLEN BURNIE, MARYLAND 21061 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respirefory errest, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Prevmonia Immediate Couse (Finel disease or condition resulting in deeth) /Medical a Examiner to (or es e consequence of): Physician/Medical Examiner il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last the burial-trai Due to (or es e consequence of): Due to (or as e consequence of): use as for Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached 1 | Yes 2 | No. 3 | Probably 4 | Unknown Completed by 8 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? should page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 No ector, 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Inpetient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. injury et Work? 28d. Describe how injury occurred 5 ☐ Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 🔯 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. Medicai 29a. Certifier Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end manner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Sherif Elassal, MD January, 18, 1998 Be 5333644 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 301 Hospital Drive Glen burnie 21061 Sheil Elassa North Aroundal Hospital JAN 2 0 1998 Strerte Signature Randall

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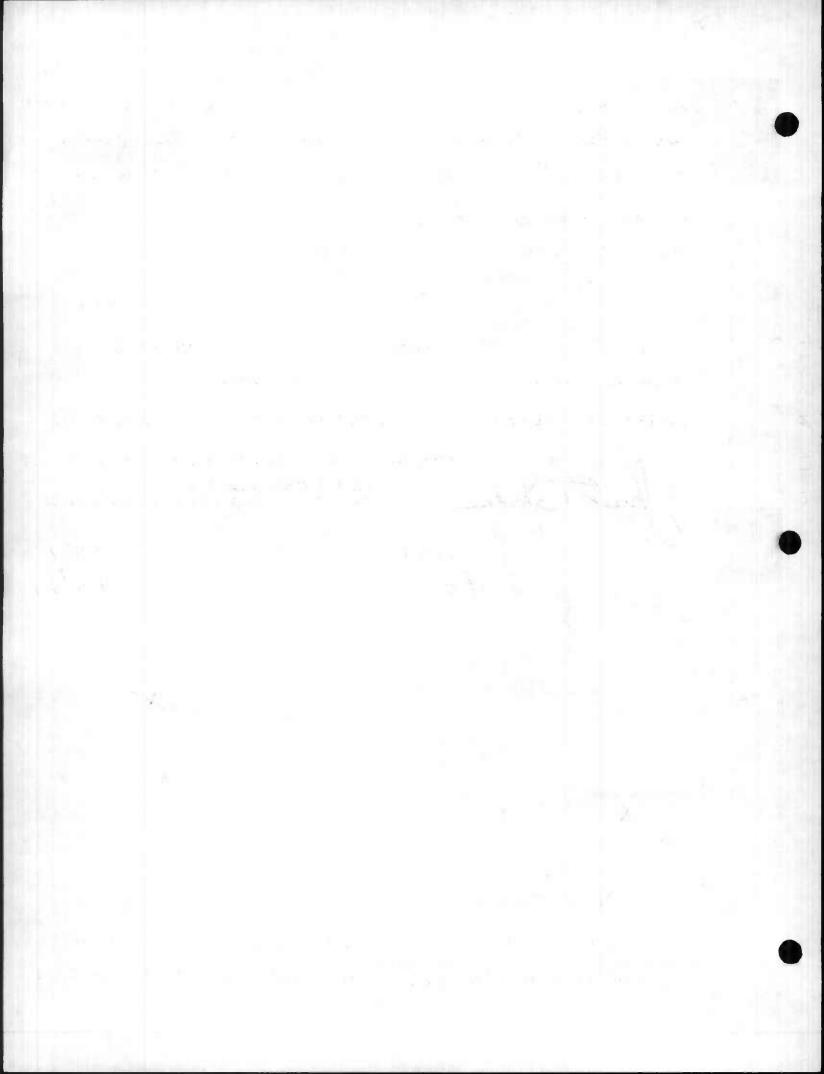
State Registrar

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Box 68760.

Division of Vital Records, P.O.

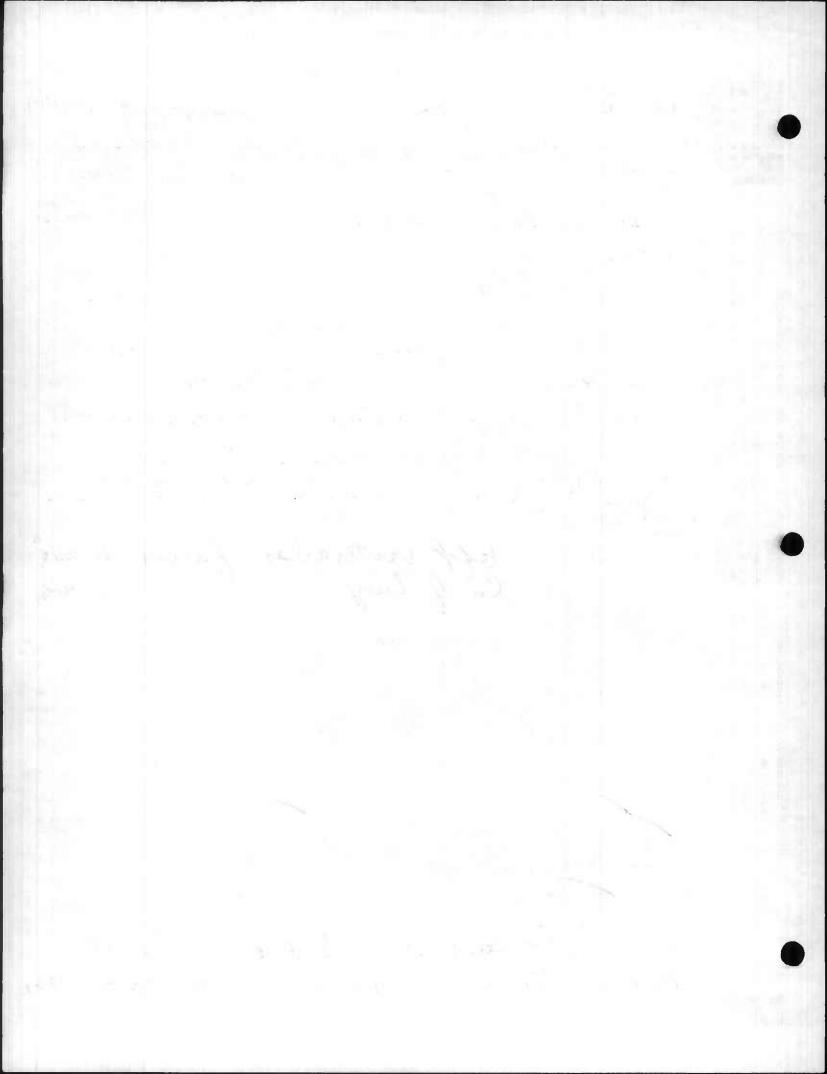


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month luane 7:42AM Vanuary 15, 1998 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** HEALTH OF GLEN BURNIE GLEN BURNIE ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sax Birthplace (State or Foreign Country) **Funeral №** M 2□ F Months Deys Hours 225-82-2899 43 Yrs. Director MARYLAND SEPT.25, 1954 Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ma 23a or 28a-f show Director 1 Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? P.O. BOX 785 21060 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 200No If Yes, Give Yeer or Dates: Herna 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Marital Status the Medical Examiner Peges 1 and 2 should be filed within 72 hours after nent of Health and Mentai Hygiene. Int: If Item 27 Is marked other than "natural", or Hei 1 Never Married 2 Married 21215-0020 1 Yes No Specify: WHITE þ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) PRINTER PUBLISHING 12 Ith and Mental Hygie 27 Is marked other in traumatic event, in N/ABaltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be WILLIAM PHILLIP STSK HAZEL DRIUSSELA ASHENFELTER 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARLEEN GARLAND (SISTER) 109 SHORE DRIVE, SHILOH, NORTH CAROLINA other 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stele ò permit. Pege Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY. INC. BELTSVILLE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, ature of Funeral Service License 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, r heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bunal-trar as a consequence Box 68760, Physician/Medicai Due to (or es e consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by til 2 should be detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown p Records, Completed 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? certificate has 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Sidi the funeral 27. Menner of Death Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury el Work? After Division Attending 5 Pending investigation 1 Naturel death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide in by t 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospital within 24 hours a To the Funeral C Medical 11 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature and title of cortfier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 0 1998

NANK us 7070 Mithie Hy - Cley Burne up 2106)
32. Registrar's Signature
Burne Rendell

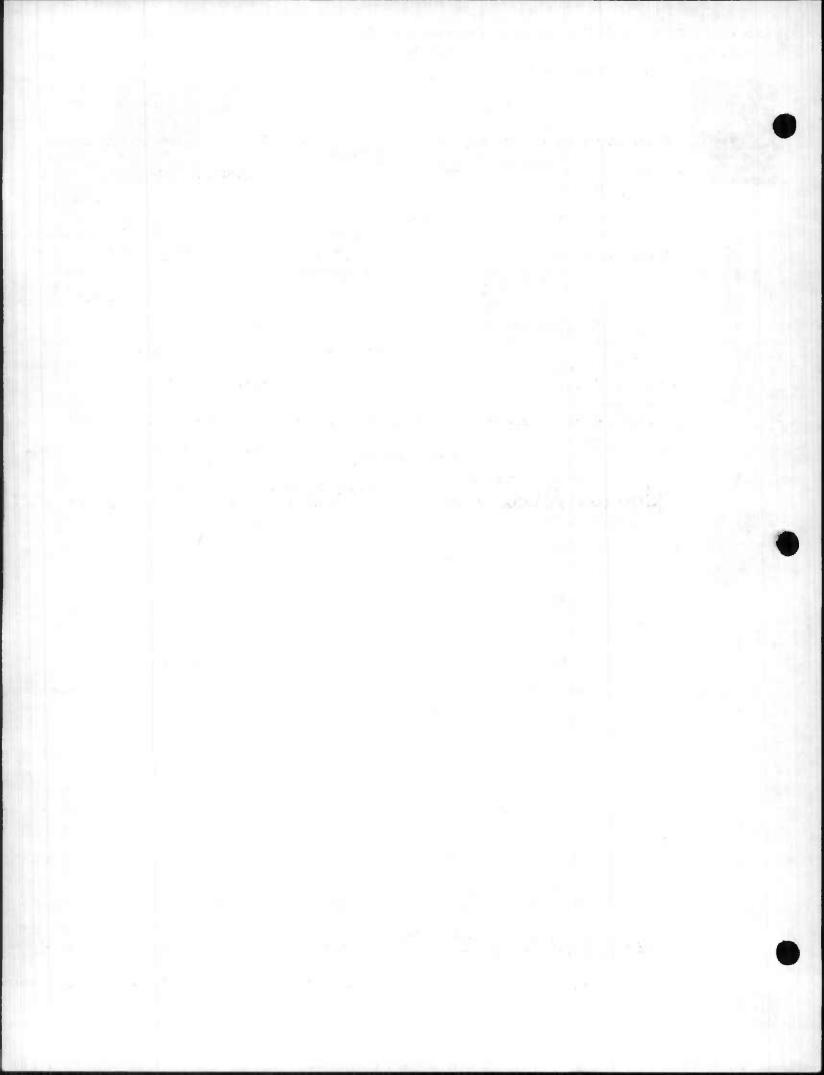


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State of Maryland / Department of Health and Mental Hygiene 9 8 0 2 8 5 9

							Certific	ate of	Death		Reg. No.		
			1. Decedent's Nema (First, Middla, L	ast)	1 7					2. Data of De	ath	V	3. Tima of Death
	Physic /Medi		Genevieve	Sc	hoch					Januar	y 11, 1	998	5:30 A.M.
	Exami		4a. Facility Nama (If not institution, g	iva street and nu	m <i>ber</i>)				4b. City, Town, or	Location of Deat	4c. County	of Death	
			Shady Grove Adv	ventist	Hospit	al			Rockvil	le	Montg	omery	County
	Funeral Director		5. Social Sacurity Number 6. 057-03-5765 Usual Rasidance of Decedent	Sax 1□M 2∏F	7. Aga (In yr		thday) If Un Mont	ndar 1 Yaai hs Days		. (Month, Da	th by, Year) 7, 1914	9. Birthi Coul Penns	olaca (Stata or Foraigr otry) sylvania
dand	M W		10a. Stata 10b. County		10c. C	ity, Tow	n or Location					T	10d. insida City Limits
Man	18	ţō	Pennsylvania Son	nerset	Me	yers	dale						1X Yas 2 No
h with the	st be not	al Director	10e. Street and Number 304 Lincoln Avenu	1e			10f.	Zip Coda	2		10g. Citizan of United		es
5-UUZU 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items of show any lollury or other traumatic event, the Medical Examinar must be notified at ADICS.	by Funeral	11. Marital Status 1 □ Naver Married 2 □ Married 3 ☑ Widowad 4 □ Divorced	12. Was Dece Armed Fo 1 Yas If Yas, Giv Yaar or D	rcas? 2∭No ∕a	U,S.			Hispanic Origin? (ban, Maxicen, Pua Specify:	Specify Yas or No rto Rican, atc.)		ca - Amarick, Whita,	can Indian,
5-C	natur Scal	Completed	15. Decedant's (Specify only highast g	Education		16a.	Decedent's U	Jsual Occu	pation	orkina	16b. Kind of B	usinass/in	dustry
ithin	an °c	nple	Elementary/Secondary (0-12)	College (1	1-4or 5+)				during most of we	orking			
₩ %	ygien er th	S	8				Ho	memak			Own :		
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y ould	Merke	2	George Franklin		r					izabeth			
Val 12 sh	Is I		19a. Informent's Name/Ralationship							Rural Route Numb			
and I	Healtl m 27 ther t		Suszanne Schoch/	Daugnte	-		Disposition (Star Ko	ad, Germ			
Daillillore, Maryland 21213-0020 Semit. Peges 1 and 2 should be filed within 72 hours af	ment of I ant: If ite lury or o		20a. Mathod of Disposition M☐ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec		State	camatar	y, crematory Cemete	or other pla		January 14, 1998	Meyers Pennsy	dale.	
Daill.	Depart import any in		21. Signatura of Funaral Sarvice Lice	1	0690		Leck	emby		Home (P			lvania 155
/	ysician Medical		23a. Part1. Enter the disease, or co shock, or heart failura. List onl Immediata Causa (Final disease or condition	y ona ca <i>u</i> sa on a	aused tha da ach line.			noda of dy	ing, such as cardie	ac or respiratory a	rrast,		Approximate intervel Batween Onsat and Death
E	aminer		resulting in death)	a			consequance	ot):	П.			1	
P	#1	-lue		. b								1	
e execute	ian end uriel-trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	D	Due to	(or as a c	consaquance	of):					
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et the d	ched	ysl	Part ii. Other eignificant conditions	contributing to de	eath but not ra	sulting in	tha undarlyin	ng causa g	van in Part i.				o the cause of death
thet	ed by dete									10	Yes 🎾 No	3 ☐ Pro	bably 4 ☐ Unknow
The law requires thet the deeth	shoul	Completed by									an autopsy ormed?	av	ara autopsy tindings ailabla prior to emplation of ceusa deeth?
he la	e hes age 2	mo								10	Yas 2√□No		☐ Yas 2☐ No
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Physician:	s certificate he director, page	To B	axaminer? 1 ☐ Yas 2X No	Hospitel:	npatiant 2[∃ER/Ou	tnatient 3□	DOA O	hor	Homa 5 ☐ Rask		ar (Snecil	(v)
Attending Phy			27. Mennar of Death 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigati	28e. Date (Mont		28b. T	Time of njury	28c. Inju		T	how Injury occur		<i>y</i> /
DIVISION OF VICAL DECORD If or Attending Physician: The law require	within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicida 6 Could not determine	286. Place	ot Injury - At ng, atc. (Spac	home, ta	rm, street, tac	etory, office		28t. Location (: City or Tox		per or Rure	al Route Number,
To the Hospital	within 24 hours To the Funeral completely filled	edical	29a. Cartifiar (Check only one) 1X Certifying P	miner: On the be	best of my kr asis of examin ner stated.	owladga ation and	, death occurr d/or invastigat	red et the t tion, in my	me, dete end plec opinion, death occ	e, end dua to tha curred et tha tima,	causa(s) and modata and place,	enner es s and dua t	teted. tha ceusa(s)
To th	Nithir To th	M	29b. Signature and title of certifier	,	0	_		29c. Lican	sa numbar		29d. Data signa	d (Month,	Day, Yaar)
	-, 0		+ Louisly 1	. HARAS	este	MI	>	D324	07		TANIMAD	V 11	0,1998
			30. Nama and address of person with	complete	e ot death (Its	m 23a) (Type, Print)				MUNK	7 14	1110
			Joseph M. Hagger					enter	Drive	Rockvill	e. Mary	land	20850
	Sta	ate	31. Data tilad (Month, Day, Year)	32. R	egistrar's Sign	natura	ILCAI U	ence!	DITAE,	MOCKVIII	.c, mary	Land	20030
	Regist		31. Data tiled (Month, Day, Year) JAN 2 0 199	18 5	egistrar's Sign	bor-1	fandell						

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State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time Death Month **Physician** 3, 1998° January 10:30 PM Dorothy Sopko /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner NIH. The Clinical Center Bethesda Montgomery 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplece (Stete or Foreign Country) 3 Pennsylvania 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1 M 200 Months Deys Hours 161-26-4604 Yrs. 64 March 24, 1933 Director Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1√2 Yes 2 No Director PA Lackawanna Taylor 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 18517 409 West Grove Street United States of America death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mentel Hygiene. Important If Item 27 is marked other than "natural". And the pages of the traumatic events. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 3 No If Yes, Give Year or Detes: 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Secretary Emery Air Freight -12-17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be John Sopko Anna Mekilo 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) John Sopko - Brother 407 Cooper Street Taylor, Pennsylvania 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBuriel 2 ☐ Cremetton 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) St. Mary's Byzantine Cem. 1/8/98 Taylor, Pennsylvania 22. Name and Address of Facility Semian Funeral Home 21. Signature of Fanerel Service Licanses Park. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, pock, or peert feilure. List only one cause on each line. 704 Union Street Taylor, PA 18517 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Fine) Aspiration Pneumonitis / ARDS 16 Hours diseese or condition resulting In deeth) Examiner Due to (or es e consequence of): Examiner Advanced Colon Cancer physician and s the buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): that the death certificate be exec P.O. Box 68760. Physician/Medical Due to (or es a consequence of): attending been signed by the atta should be datached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes XX No 3 □ Probably 4 □ Unknown Records, þ 24b. Were autopsy findings eveileble prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? page 2 hes 1 Yes 2 No 1 ☐ Yes 200No certificate Division of Vital Be 25. Wes case referred to medical 28. Pleca of Deeth (Check only one) examiner? Hospitel: Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XXNo 2 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28a. Dete of Injury (Month, Dey Yeer) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending Investigation 1 Divaturel death. 1 ☐ Yes 2 ☐ No f or Attend after death Director: / 2 Accident To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide **ECertifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) and menner as stated.

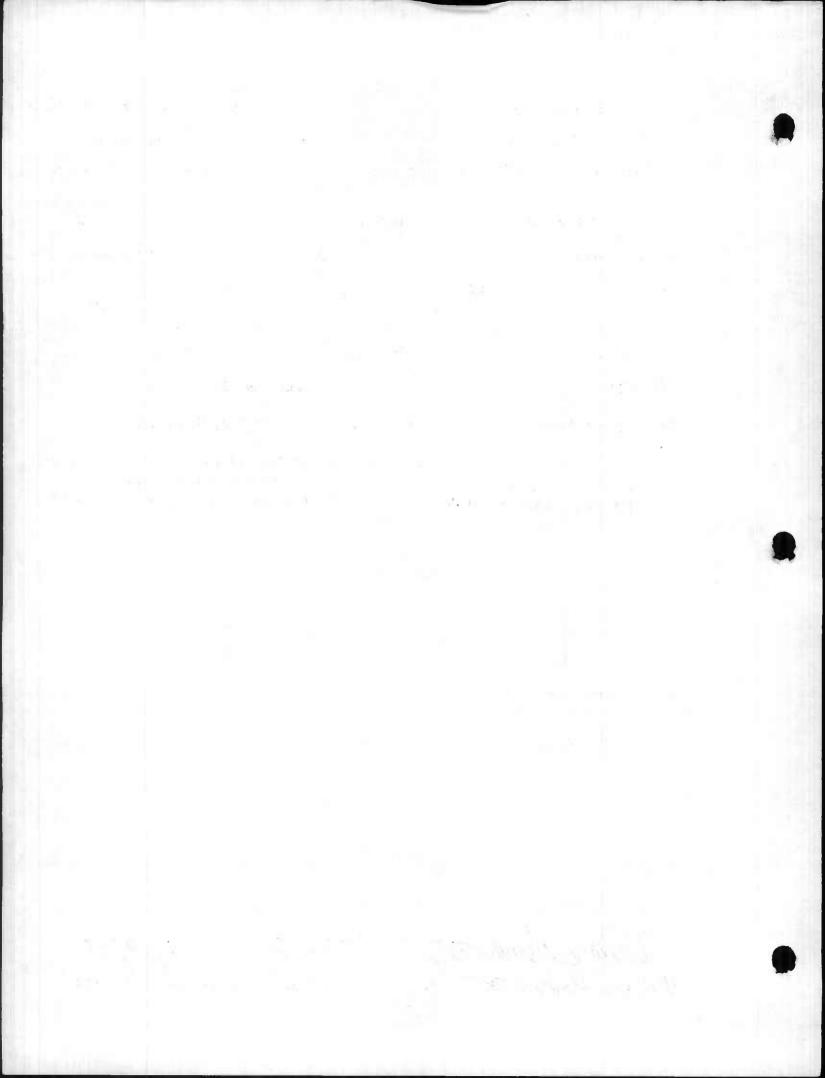
2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. License number Federal Institution 29d. Date signed (Month, Day, Year) 8 No Number end eddress of person empleted cause of deeth (Item 23a) (Type, Print) allace MONDESIRE 9000 Rockville Pike Bethesda, Maryland 20892 31. Dete filed (Month, Day, Yeer) whia Davidson-Randell 32. Registrer's Signeture

DHMH 16 Rev 6/95

State

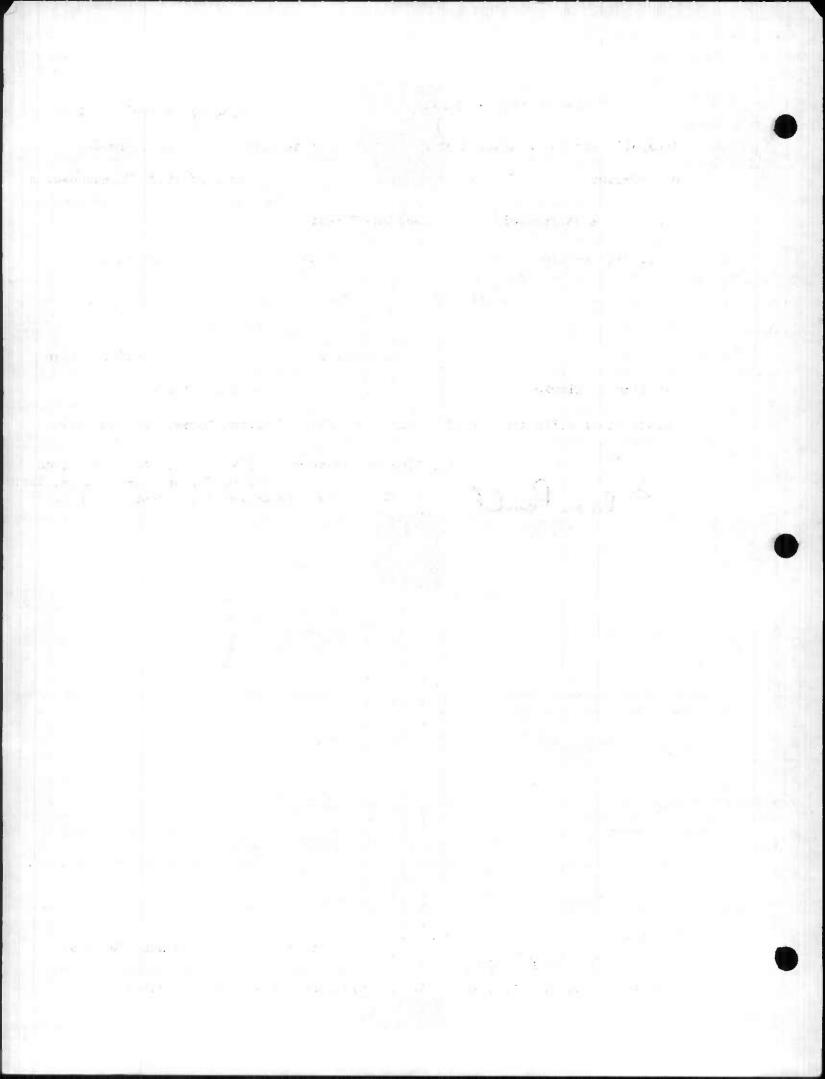
Registrar

JAN 2 0 1998



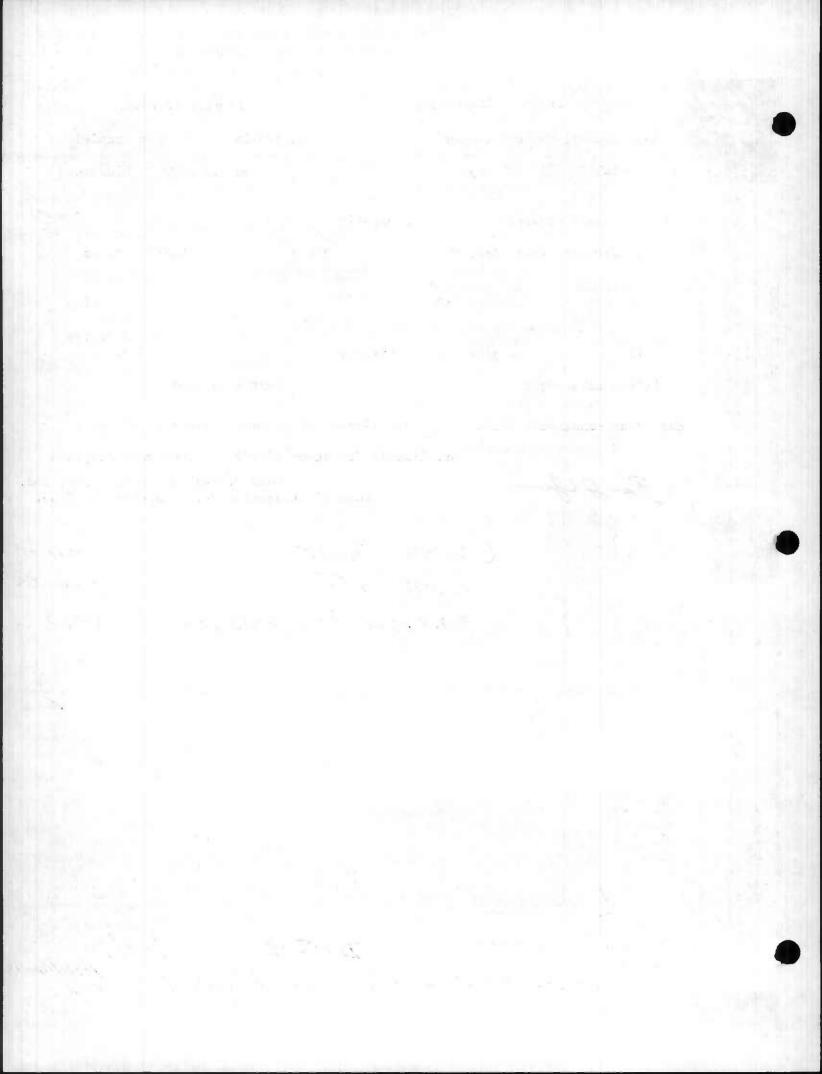
State of Maryland / Department of Health and Mental Hygiene

mar .		1. Decedent's Neme (First, Middle, Last						2. Dete of Deet			. Time of Deeth
Physicia /Medic		Eleanore	Clarke	Smal	.1			Month January	Dey 19 199	Year 98	2:09PM
Examin		4e. Fecility Neme (if not institution, give	street end number)				4b. City, Town, or L		4c. County		2.00111
		Annapolis Nursing	& Rehab	Cente	er		Annapoli	S	Anne	Arunde	1
uneral		Sociel Security Number 6. Security Number	7. Ag	ge (In yrs. le	est birthdey)	If Under 1 Yee Months Dev		8. Dete of Birth (Month, Dey,	Year)	9. Birthplece	(Stete or Fore
irector		010-07-5506	JM 280 F	90	Yrs.			Sept 27			husette
ž		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City	Town or Loc	ation				10d I	Inside City Lim
4.7	lor	MD Anne Ar	undel		Sherwo	od Fore	est				1 □ Yes 2 🔯 I
28e	Director	10e. Street end Number				10f. Zip Code		10	0g. Citizen of \	Whet Country?	
3a o		411 Alan-A-Dale				21	405		United	States	
	Funeral	11. Maritel Stetus	12. Wes Decedent Armed Forces?	Ever in U,S	6. 13. W	Vas Decedent of	Hispenic Origin? (Sp ben, Mexican, Puerto		14. Red	e - American I	
"natural", or items 23s or 28s-f show solical Examiner must be notified at	by Fu	1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☒ळworced	1 Yes 2 H			Yes, specify Cu		Hican, etc.)	Specify	ck, White, etc. Whit	e
cal E	pet	15. Decedent's Edu	cation		16e. Decede	ent's Usuel Occu	pation		16b. Kind of B	usiness/Industr	ry
r than "natur re Medical	Completed	(Specify only highest gred Elementery/Secondery (0-12)	completed) College (1-4or !	54)	(Give k	kind of work don OO NOT use retir	e during most of work ed)	king			
r than	mo.	12		,,	Γ	ecorato)	r		Inte	erior D	esign
후 늘	Be	17. Father's Neme (First, Middle, Last)						ne (First, Middle, N		ne)	
	10	William J. Clark	е	1.4			An	nie D.	Pardy		
tam 27 la marko		19a. Informent's Neme/Relationship (Ty					et and Number or Ru				
itam 27 other tr		Linda Small Smit	n (Daugnt	-		Alan-A-D sition (Name of	ale Sher	wood For			
or its		20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	emovei from State	Ce	metery, crem	etory or other pl			20c. Location -	City or Town,	Stete
nluny				Ft.			atory 1/2			wood, Ma	
Important: If its any injury or of once.		21. Signeture of Funerel Service License	200				ress of FecilityJoh of Glouce				
/siclan ledical		23a. Pert1. Enter the disease, or complishock, or heart feilure. List only or Immedlete Ceuse (Finel disease or condition				r the mode of dy	ring, such es cardiec	or respiretory erre	est,	On	proximete ervel Between set end Deeth Month
aminer		resulting in death)	Kena	1 Fai	es e consequ	uence of):				1	MOIILII
2	Examiner		Athe	roscl	erois					Ma	ny Yea
trans	Cam	Sequentially list conditions,)	Due to (or	es e consequ	uence of):					
physician and s the buriel-transit		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events									
physi the	edical	that initieted events resulting in deeth) Lest		Due to (or	es e consequ	ence of):					
D) 65											
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ed by the attendin deteched for use	Physician/N	Part II. Other significant conditions con	tributing to death b	ut not resul	ting in the un	derlying cause g	iven In Pert I.			ntribute to the	
dete	by Pi							1 U Ye	s 2□No	3 Probabl	y MUNKN
been signed the standard stand	Q Da							24e. Wes er		24b. Were a	utopsy finding
s pee	Completed							perform	ned?		ele prior to etion of cause h?
ata has page 2	mo							1 ☐ Ye	s 2 No		s 2 No
certificata rector, pag	BeC	25. Wes case referred to medical					28. Plece of Dee	th (Check only on			
0 0	10	examiner? 1 Yes 2 XIX	lospitel:	ent 2 E	R/Outpatient	3 DOA	thor	ome 5 Reside		er (Specify)	
fter th		27. Menner of Deeth 1∑Neturel 5 □ Pending	28a. Dete of Inju (Month, De	y Year)	28b. Time of Injury	28c. Inj	ury at ork?	28d. Describe ho	w Injury occur	red	
or: Al	catic	2 ☐ Accident Investigation			, , ,		Tes 2□No				
To the Funeral Diractor: After the completely filled in by the funeral	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Plece of Injuding, etc.	ury - At hor c. (Specify)	ne, ferm, stre	et, factory, office		28f. Location (St. City or Town	reet and Numb n, Stete)	er or Rural Ro	ute Number,
To the Funeral I completely filled	edical	29e. Certifier (Check only one) 1 ★ Certifying Physical Examination (Check only one)	ner: On the basis of	exeminete	ledge, deeth on end/or Inve	occurred et the estigetion, in my	time, dete end piece, opinion, deeth occur	end due to the ca red et the time, de	nuse(s) end me ete end plece,	enner es stated and due to the	t. ceuse(s)
on the	Me	29b. Signature and title of certifief	and menner ste	9190.	1	29c. Licer	nse number	25	9d. Date signe	d (Month, Dey,	Year)
2 8		VI) 1141	// -		110	200, 200	D05192		January		
-									January	20. 1	770
		30. Neme end address of person who co	leu	7 0	0	>	D03172		January	20, 1	330



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month 17 1998 Arnold. Robert Schuknecht January 7:43 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. Aug 23 1923 5. Social Sacurity Number 9. Birthplaca (Stata or Foraign Country) Minnesota 7. Aga (In yrs. last birthday) **Funeral** 1₽M 2□ F Months Yrs. Director 536-18-8183 74 Usual Rasidance of Decedan 10a State 10b County 10c. City. Town or Location raf, or items 23a or 28a-f show Examiner count be notified at 10d. Insida City Limits 1 Yas 2□No Director Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code 10g, Citizan of What Country? 1054 Eaglewood Road Apt. TC 21403 United States death Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 XX s 2 □ No 1941 – If Yas, Giva Yaar or Datas: 1969 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. should be filled within 72 hours effer and Mental Hygiene. marked other than "natural", or ite 1 Navar Married 2KM Married 21215-0020 1 ☐ Yas 2 No Specify: py Specify 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry United States Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 Officer 4 plus Navv Baltimore, Maryland 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Pages 1 and 2 should be nent of Health end Mental William Schuknecht Bertha Hardies 19a. Informent's Name/Ralationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) .00 nt of Health e : If itam 27 is r or other train 1908 Sleepy Hallow Lane Annapolis, MD 21401 Mary Jean Schuknecht (Wife) 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata permit. Page Department of Important: If any Injury or once. Ft. Lincoln Crematory 1/19/98 Brentwood, Maryland 4 ☐ Donation 5 ☐ Othar (Spacify) 22. Nama and Addrass of Facilityohn M. Taylor Funeral Home, Inc. 21. Signature of Funaral Servica Licensaa 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final diseese or condition rasulting In death) /Medical MMUDIATE Examiner Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Ceuse (Diseasa or injury that initiated avants rasulting in daath) Last pue P.O. Box 68760, Physician/Medical signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 MUnknown Records. by Completed 24b. Wara autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital Hospital or Attending Physician: director Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28b. Tima of 28d. Dascribe how injury occurred 28e. Deta of Injury (Month, Day Year) 28c. Injury et Work? After Division 1 Naturel 5 Pending investigation 1 Yas 2 No death. 2 Accidant within 24 hours efter death To the Funeral Director: / completely filled in by the 3 Sulcida 6 Could not be datarminad 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 Homleida 1 Cartifying Physician: To the best of my knowladga, daath occurred at the time, data and place, and dua to tha causa(s) and menner as steled.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to the causa(s) cai 29e. Certifian and mannar statad. To the 29b. Signatura and title 29c. Licansa numbar 29d. Data signad (Month, Day, Yaar) 2003 MEDER PRUY ANNAPOLIS 30. Nama and actives of person who complated causa of death (Itam 23e) (Type, Print) Anschuth MI 31. Dete filed (Month, Day, Yaar) 32. Registrar's Signatura State JAN 2 0 1998 whia Davidson Registrar



MARIE FRANCES STEWART DIVISION OF VITAL RECORDS. P.O. BOX 68760.

			CERTIF	ICATE OF	DEATH	MENTAL HY	S. NO.		
	1. DECEDENT'S NAME (First, Middle, La Marie Fra:					2. DATE OF DE		(A)	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIR	1 1111	70 (CE (State or Foreig
	208-12-5850 9e. FACILITY NAME (If not institution, gi	1 □ M 2 🔀 F 72	YRS.	MONTHS DAYS	HOURS MIN.	Nov. 2	5, 1925	Penns	ylvania
CTOR	Carroll County	General Hospi	tal		on Location of i	DEATH		of DEATH	
EC	10a. STATE 10b. COU		10c. CITY	r, TOWN OR LOCA	ITION			10d	I. INSIDE CITY
DIRE		rroll		Sykesvi	lle				LIMITS?
ERAL	10e. STREET AND NUMBER			10	H. ZIP CODE		10g. CITIZE	N OF WHAT	COUNTRY?
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BY FI	1 Naver Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 X NO	If yea, s	pecify Cuban, Maxie S 2 X NO Spec	an, Puerto Rican, at	ic.)	Black, Wh	American Indian, hite, atc. White
ETED	15. DECEDENT'S E (Specify only highest gr	DUCATION ade completed)	18a. DECEOENT'S	rork done during m	ON ost of working	16b. KIND (F BUSINESS/INDUS	TRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Office	e Manage	er		lerical		
COMPL	17. FATHER'S NAME (First, Middle, Last)		02220	C ranag		Clerical (HER'S NAME (First, Middle, Maiden Surname)			
TO BE	Carmen Bels	sito				zabeth :			
	19a. INFORMANT'S NAME (Type/Print)	(son)				Route Number, City			
	Mr. Warner Stev	201-	PLACE AND DATE O			2 Timonii	um, MD 2'		
	1X Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify)	amoval from Stata come	etery, crematory or other	her place)			Sykesvi		
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE		22. NAME A	ND ADDRESS OF F				
	23. PART i. Enter the diseases, or heart failure	L. Hauftm		Sykes	sville.	MD 21784	(410)-7	95-14	
CAL CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury	с.	CONSEQUENCE OF):		14/13E			1 we
	that initiated eventa								
N. N.	that initiated eventa resulting in death) LAST PART II. Other significant conditions that it is a significant condition to the significant conditions that initiated events are significant conditions.	dons contributing to deeth bu	t not reaulting in	tha underlyin	g cause given in	PE	AS AN AUTOPSY RFORMEO? ES 2 NO	COM OF 0	LABLE PRIOR TO IPLETION OF CAUS DEATH?
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State of Maryland / Department of Health and Mental Hygiene

2. Data of Daeth

3. Time of Death

Certificate of Death

Physician /Medical `Examiner

1. Decedant's Neme (First, Middla, Last)

Director

the Maryland filed within 72 hours efter death with Hygiana. r than "natural", or items 23s or the Medical Examiner must be

Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be file Department of Health end Mentel Hy important: if item 27 is marked othe any injury or other traumatic event.

Physician /Medical Examiner

chysician end the bunel-trensit as for use as signed t

the death certificate be axecuted Division of Vital Records, P.O. Box 68760, Attending Physician: death. after Direct 24 hours after Funeral Dire letaly filled in b To the Hosp within 24 hor To the Fune completaly fi

SHUMATE 5.27 AM DELMER JACKSON 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death COUNTY GENERAL HOSP Westminster Carrol1 7. Aga (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Data of Birth (Month, Day, Yaar) 5. Social Security Number Birthplace (State or Foraign Country) Months 1 M 2 □ F 228-54-8913 54 Yrs. Aug 6 1943 Virginia Usual Rasidenca of Decedent 10c. City, Town or Location 10a Stata 10b. County 10d. Insida City Limits 1 ☐ Yes 2 No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 859 Snowfall Way 21157 United States Funerai 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yeer or Datas: 14. Race - American Indien, Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) Black, Whita, atc. 1 Navar Married 20 Marriad 1 ☐ Yes 2 No Specify: Specify: white by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade complated) Elemantary/Secondary (0-12) College (1-4or 5+) Director/Environmental Ser. Nursing Home 18. Mothar's Nama (First, Middla, Maidan Surname) 17. Fathar's Name (First, Middla, Last) Be Raymond Shumate Fannie Bish 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19e. Informant's Name/Ralationship (Type, Print) Carolyn Shumate, wife 859 Snowfall Way, Westminster, MD 21157 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Jan 23 1998 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 XBurlal 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Westminster Cemetery Westminster, MD 21. Signatura of Funaral Sarvica Licensaa 22. Nama and Addrass of Facility Pritts Funeral Home & Chapel Kathurie Pritto - Sweither 412 Washington Rd., Westminster, MD

23a. Part1. Enter the disease, or complications that caused we death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line.

Approximation and the state of the state Approximata Interval Between Onsat and Deeth Immediata Causa (Final diseasa or condition rasulting in death) ACUTE MYOCARDIAL INFARCTION Examiner CARDIOGENIC SHOCK. Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Due to (or as a consaquanca of): Physician/Medicai Dua to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? Sepsis 1 Yes 2 No 3 Probably 4 Onknown by of liver. 24b. Were eutopsy findings available prior to Circhosis 24e. Wes en eutopsy performed? Completed completion of cause of deeth? Diabetes Mellitus Hypertension. 1 Yas 2 No 1 Tyas 2 No 25. Was casa rafarrad to medical axaminar?

1 Yes 2 No Be 26. Place of Daath (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Time of Certification: 1 Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, end due to tha cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated.

29ç. Licansa number

D39502 MD

29d. Data signed (Month, Day, Year)

402115

1/20198

Registrar

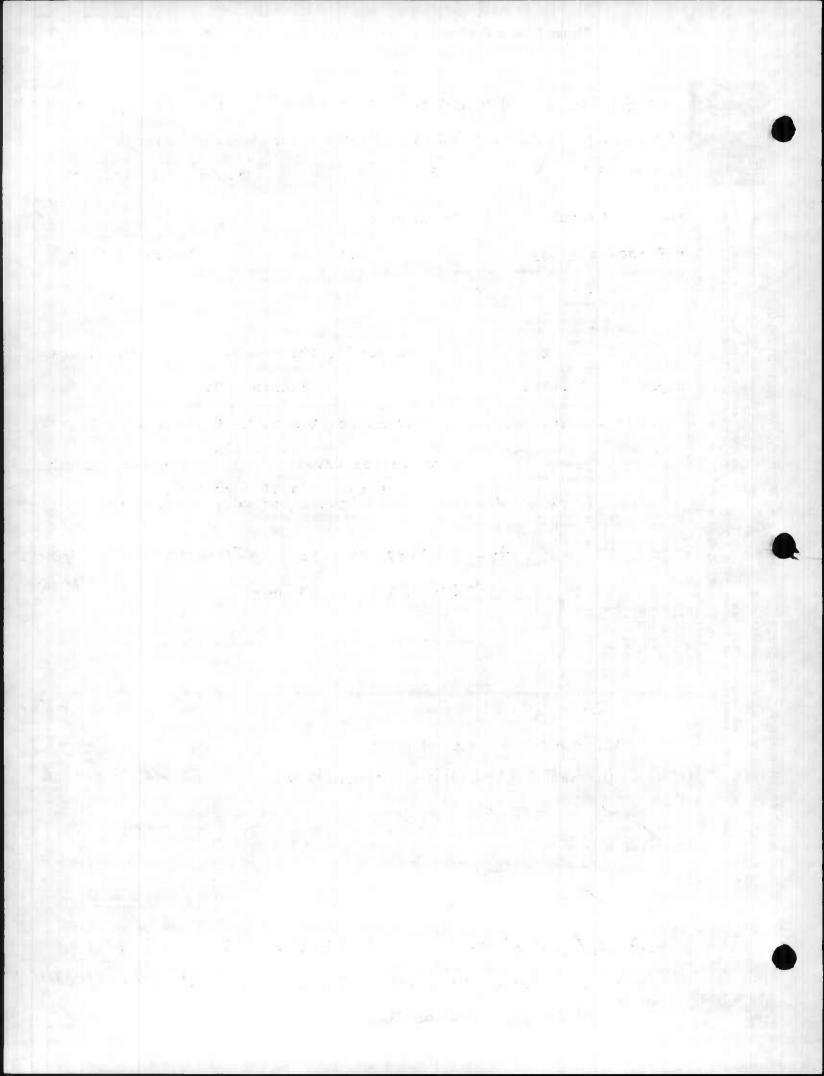
edicai

(Check only one)

29b. Signature and titla of cartifiar

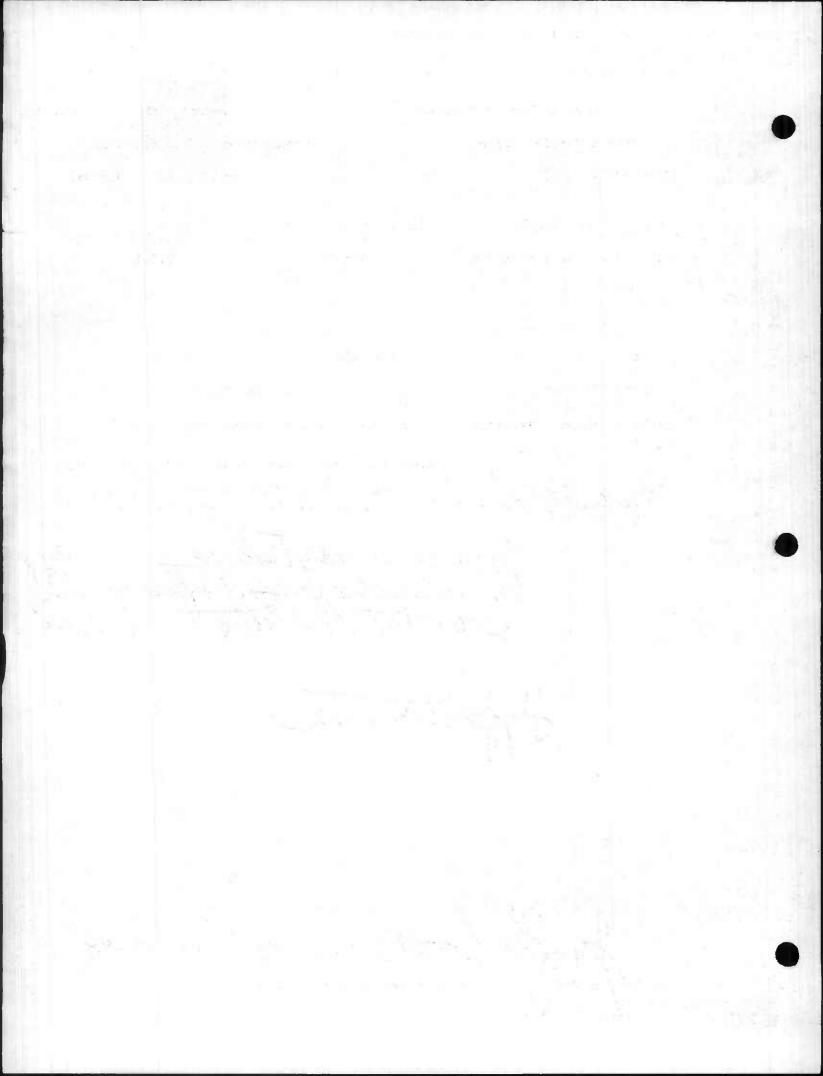
30. Name and eddress of person who completed cause of daeth (Hem 23e) (Type, Print), SYED - S. ITOS ATN MS. 412, Malcolm Drive Westminster 32. Registrar's Signatura 31. Data filed (Month, Day, Year) JAN 2 1 1998 Julia Davidsor Revolate

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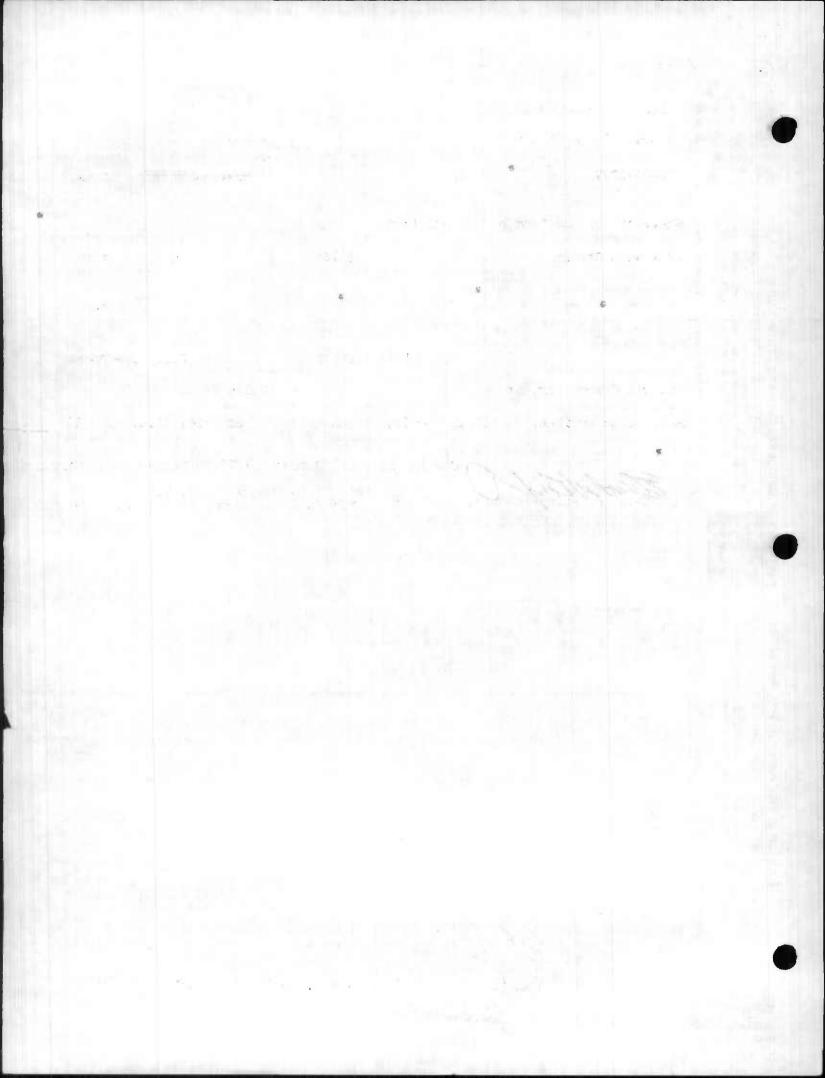


State of Maryland / Department of Health and Mental Hygiene 9

					Certificate of		R	eg. No.	0 2 0 6 3
Physic	ion	1. Decedant's Nama (First, Middla, La	ast)				2. Data of Dea Month	th Day	3. Time of Death
Physic /Medi		Doroth	y Marion S	Stringer			January		6:00 P.M.
Exami		4e. Fecility Name (If not institution, gi				4b. City, Town, or Le		4c. County	
		St. Mary's Nurs	ing Center			Leonard	town	St.	Mary's
Funeral			Sax · 7. Ag	ge (In yrs. last bir	Months Day		8. Data of Birth (Month, Day)	Yaar)	Birthplece (Stata or Foraign Country)
Director		220-07-9101 Usual Rasidance of Dacedant	IUM ZLAP	80	Yrs.		April 10		Maryland
dand ww		10a. State 10b. County		10c. City, Tow	n or Location				10d. Insida City Limits
Many	to	Maryland St. Ma	rule.	T.o.	onardtown				1 ☐ Yas 2 ☐ No
r 284	Funeral Director	10e. Street end Numbar	ity s		10f. Zip Code	9	1	0g. Citizan of V	Vhat Country?
3a o	O	2310 Cedar Lane	Anartments		20650)		U.S.A	
deat deat	ner	11. Marital Status	12. Wes Decedant	Evar in U.S.		of Hispenic Origin? (Sp uban, Mexican, Puerto	ecify Yas or No-	14. Rac	e - Amarican Indian,
21215-0020 d within 72 hours effer death with the Maryland giene. In than "natural", or flams 23s or 28s-f show in the Macical Examinar must be notified at	by	1 Never Marriad 2 Married 3 XWidowad 4 Divorced	Armed Forcas? 1 ☐ Yas 2 ☐ If Yes, Give Yaar or Datas:		If Yes, specify C		Rican, atc.)	Specify	
2 hou	Ped	15. Decedant's E	ducation	16a.	Decedant's Usuel Occ	cupation		16b. Kind of Bu	White usiness/industry
within 7 and then on the Media	Completed	(Specify only highast gr Elementery/Secondary (0-12)	ada com <i>platad)</i> College (1-4or	54)	(Giva kind of work dor lifa. DO NOT usa rat	na during most of work ired)	ring		,
	EO.	8th	College (1-40)		Nurses Aid			Hospi	tal
be filed that Hygid d other	Be	17. Fathar's Nama (First, Middla, Last)			18. Mothar's Name	a (First, Middla, I		
Maryland d 2 should be file th end Mental Hy 7 Is marked othe traumatic event	To	Nelson Tinsle	у			Lavina	a Franci	S	
re, Maryla s 1 end 2 should I Heelth end Men tem 27 is marks other traumatic	ľ	19a. Informant's Name/Ralationship	(Typa, Pnnt)	19b	Mailing Address (Stra	aat and Number or Run	al Routa Numbar	, City or Town,	Stata, Zip Coda)
C = 0 -		Marsha Merchant	Daughter	39	674 Cecil	Avenue Lec	onardtow	n, MD 2	0650
Baltimore, semit. Pages 1 e Department of Hee mportant: if Item inty Injury or othe Mce.		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Crametlon 3	Domesial from Chat-	20b. Place of cematar	Disposition (Name of y, cramatory or other p	place)	Data	20c. Location -	City or Town, Stata
Baltimor bemit. Pages Department of I mportent: if Its any Injury or o		4 ☐ Donetion 5 ☐ Othar (Speci		St And	ew's Eniscon	al Cemetery	1/14/98	Californ	nia Maryland
Balt pemit. Departmental Importa		21. Signatula of Funaral Sarvice Lice	ngae /	0	22. Name end Add	drass of Facility			
o 88 E 8 8		Muland	Las	Simon		ey-Gardine			
		23a. Part1. Inter tha disaasa, or con	plications that cause	d the daath. Do r	P.O. Box	ying, such as cardiac	ardtown, or respiratory arm	Maryl.	and 20650 Approximate
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/Medical		Immediata Causa (Final disaasa or condition	Na	Vin	ulma.	MARTIN	Vina	^	Day
Examiner		rasulting in death)	·	Due to (or asia)	consequence off	ory vari	upe	111 .	or o'
70 .≃	Examiner	The second second	Chro	nin /V	aralun	thesouls	es hisa	Kensy	in USU
ocute and trans	am	Sequantially list conditions,	B	Rue to (or an no	Softwarenon of:	11 08	ZX IVII	Line	7 /
e exe		Sequantially list conditions, if eny, laading to immediate causa. Entar Underlying Cause (Diseesa or Injury that initiated avants	1)	101/9	Ver p	Belle	41	450	1 (MVZ)
68760, ficete be executed physician end is the buriel-transit	edical	that initiated avants rasulting in daath) Last	0	Due to (or as a c	onsequence of):		V		1 1
K 6	192 1								//
Box eath cer ettendin for use	lan/	Para Harak	d						
The e	Sic	Pert II. Other significant conditions of	confributing to death b	ut not audling	the underlying cause	given in Part I.	23b. Did to	bacco use co	ntribute to the cause of death?
I Records, P.O. Box 68760, The law requires that the death certificate be executed at has been signed by the ettending physician and page 2 should be deteched for use as the buriel-transit	Physician/		Hus	21/2	more	N	1 🗆 Y	2 2 No	3 ☐ Probably 4 ☐ Unknown
S, res th	by		TIM	en	140			· · · · · · · · · · · · · · · · · · ·	
Records, he law requires the hes been signe	Completed		0 11				24a. Wes a perform	n autopsy nad?	24b. Wara eutopsy findings eveilabla prior to
es be	pie		# V						complation of cause of death?
The ate h	00						1□ Ya	as 2 🗓 No	1 ☐ Yes 2 ☒No
ita In: In: In: In: In: In: In: In: In: In:	Be (25. Was casa refarred to medical axaminar?				26. Pleca of Daati	h (Check only on	a)	
nysic nis ce I dire	2	1 Yas 2 No	Hospital: 1 Inpatie	ent 2 ER/Ou	tpatient 3 DOA	Othar: 4 Nursing Ho	ma 5 Rasida	ince 8 Oth	ar (Specify)
ng Pi		27. Manner of Death 1 XNatural 5 ☐ Panding	28e. Dete of Inju (Month, Da	ry Year) 28b. T	ima of 28c. In	jury et Vork?	28d. Describa ho	w injury occurr	ed
Sionalir Seth.	atic	2 Accidant invastigatio	n			☐ Yas 2 ☐ No			
Division of Vital or attending Physicien: 7 after deeth. Director: After this certifical of the funeral director, p	Certification:	3 ☐ Suicida 6 ☐ Could not be detarmined		ury - At homa, fa	m, straat, factory, offic	же	28f. Location (St. City or Town	raat and Numb	er or Rural Routa Number,
O of a fee	Cer						,		
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	(Check only 2 Medical Exar	nings On the basis of	examination and	daath occurred at that	tima, data and place,	and dua to the ca	ausa(s) and ma	nner as steted. and dua to tha cause(s)
the I the I	Med	1	manner str	//					
5 × 5 × 5		29b. Signatura and title of certifier	1/bn	-	29c. Lice	ense number		_	(Month, Dey, Year)
		XOLO	5/00 M	10	UID	06419		1-17	L-78
		30. Nama and edd/ess of parson who	complited cause of d	aath (Itam 23a) (Tuno Drint)	- 1			
(m)		_ / /	/ /	, , ,	** '				
(b)		J. Patrick Jarl		Leonardt ars Signature	own, Maryl	and 20650			



ARI It	DELL ELIZ ems:23a_par	ABETH SCRIBER Item:	State of N 8 per FH G-7 2/11/98 dh	Maryland 757 3/31/	/ Departm /98 Certific	ent of F	lealth and <i>Death</i>	Mental Hy	giene	02	866
	Distriction	1. Decedant's Nama (First, Middla, I	.ast)					2. Data of De Month	eath Day	Yaar	3. Time of Death
	Physician /Medical	Ardell Elizabe	th Scriber	<u> </u>				JAN.	16, 1998		2331 PM
	Examiner	4a Fecility Nama (If not institution, g		er)			4b. City, Town, o	Location of Deet	h 4c. County	of Death	
		ST.MARY'S HOSPI				adar 1 Vans	LEONARD			ARY'S	
	Funeral		Sex 7. /	Age (In yrs. les		nder 1 Yaar iths Days	If Undar 24 Hr Hours Mir		th 8/9/55 by, Year)		ce (State or Foreign
	Director	212-66-2727 Usuel Residence of Decedant		42				September	9, 1955	Mary.	Land
	show at at	10a. Stata 10b. County		10c. City,	Town or Location					100	d. Insida City Limits
	a-f al	Maryland Prince	George	Sui	tland						1 ☐ Yes 2 ■ No
	vith the Ma t or 28a-f a be nostreed	10e. Street and Number			10	. Zip Coda			10g. Citizan of V	What Country	y?
	ath w	4731 John Street				2074			United		
020	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show added Evantive must be notified at leted by Funeral Director	11. Merital Status 1 Never Marriad 2 Merried 3 Widowed 4 Divorced	12. Was Dacedar Armed Forcas 1 Yas 2 If Yas, Give Year or Datas	s? No	If Yes,	acadant of H specify Cuba as 2 No	an, Maxicen, Pua	Spacify Yas or No rto Rican, atc.)		e - Amaricer ok, Whita, at :: Blac	c.
0	natura drail	15. Decedant's			16a. Decedent's	Usuai Occup	pation	adden.	16b. Kind of Bu		
21215-0020	c	(Specify only highast (Secondary (0-12)	College (1-4o	or 5+)	lifa. DO No	OT usa ratire	during most of w d)	orking			
	Hygiene. Hygiene. Ither than		2		Civil S	Servani			U.S. go	overnm	ent
pui	tal Hy doth oth	17. Fether's Neme (First, Middle, La				- 11		ame (First, Middla	, Maidan Suman	na)	
yla	should be filed within and Mental Hygiene. I marked other than umatic event, the M							elen Ban			
Maryland	C 4 5 6	19a. Informent's Neme/Ralationship Mary Helen Scrib			at and Numbar or Rural Routa Number, City or Town, Stata, Zip C 19th Road, Mechanicsville, MD 2						
	Pages 1 an nent of Heal int: if Item 2 iry or other	20a. Mathod of Disposition	er, Mot		ce of Disposition		gii Road,	Data	20c. Location -		
nor		1 ■ Burial 2 □ Cramation 3		ta can	natary, cramatory	or othar pla					
Baltimore	pemit. Pa Departmen Important: any Injury once.	4 Donation 5 Other (Special Structure of Str	oity)	Char			Gardens ass of Facility	1/23/98	Leonard	itown,	Maryland
89	permit. Departrimporta any Inje.	Edward N. Bri	my	, ,,,,	I	Brinsf:	ield Fun	eral Hom	e, P.A.		
	Physician /Medical Examiner	23a. Pert 1. Entar the disaase, or co shock, or haart failura. List on Immediate Causa (Final disaasa or condition	mplications that caus ly ona causa on each	sad tha daath. I lina.		moda of dyir	ng, such es cardi	ac or raspiratory a	rast,		MD 20650 Approximete ntarval Batween Onset and Death
		rasulting in death)		Dua to (or a	as a consequence	of):					
x 68760,	at the death certificate be executed by the ettending physician end eteched for use as the burial-fransit Physician/Medical Examiner	Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last	c		s a consaquance						
Box											
0	that the death ed by the ette deteched for APhysicia	Part II. Other significant conditions	contributing to death	but not rasulti	ing in the underly	ing ceusa giv	van in Part I.				the cause of death?
0	5 60							. 1	Yes 2 No	3 Probe	ably 4 Unknown
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R	The law ate has page 2							· fe	Yas 2□No	157	Yes 2□ No
Vital	certificate irector, pag	25. Was cesa rafarred to madicel axaminar?					26. Place of D	eath (Check only	ona)		
of V	N S D	1XX as 2□ No	Hospital: 1 🗆 Inpa	atiant XXE	R/Outpatient 3[LOOA		Homa 5□ Ras			
n	After th uneral	27. Mannar of Daath 1/XX Natural 5 Panding		Day Year) 2	8b. Tima of Injury	28c. Injui		28d. Dascribe	how injury occur	red	
Division	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: "	2 Accident invastigat 3 Suicida 6 Could not 4 Homloida	be 28e. Place of I	Injury - At hom atc. (Specify)	M e, farm, straat, fa		Yas 2□No		(Streat and Numb wn, Stata)	per or Rural i	Routa Number,
	To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) 1 Certifying I	Physician: To the besignment on the basis and manner	of axaminatio	edga, daath occu n and/or invastig	rred at the tin ation, in my o	me, date end plac opinion, deeth occ	ce, and dua to the curred et the time,	cause(s) and me , date and place,	enner es sta and dua to t	ted. tha ceuse(s)
	Withir Comp	29b. Signatura and titla of certifiar	1001	1		29c. Licans			29d. Data signa		
			4/ 4	4		O.C	.M.E		JAN.	18, 19	198
		30. Nama and addrass of person wh	Forb-	1	11 Penn	Stree	t, Balti	more, Ma	aryland	21201	
	State Registrar	31. Data filad (Month, Day, Year) JAN 21	1998 32. Begis	strar's Signatur	-Rardall						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3 Time of Death **Physician** 1998 January 9:15 PM Paul Thomas Sullivan /Medical 4a. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Leonardtown St. Mary's Hospital St. Mary's 7. Age (In yrs. lest birthday) If Under 1 Year III Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6 Sax Birthplece (State or Foreign Country) **Funeral** 1 M 2□ F Days Yrs. Director 225-05-4891 May 31, 1922 Virginia Usual Residence of Decedant the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ■ No Director Maryland St. Mary's St. Inigoes 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 17145 Jutland Drive 20684 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 72 hours after 1 ■ Yes 2 □ No
If Yes, Give
Yeer or Detes: 1942–1945 1 ☐ Nevar Married 2 ■ Married "natural", or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiana. Pagas 1 and 2 should be filed within nent of Haaith and Mantal Hygiana. nt: If Item 27 is marked other than "iry or other traumatic event, the Ma Elementery/Secondary (0-12) College (1-4or 5+) Supervisor Postal Service 11 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Benjamin Franklin Sullivan Annie Bernadette Hogan 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Virginia E. Sullivan, Wife P.O. Box 85, St. Inigoes, Maryland 20684 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ■ Burlal 2 Cremetion 3 Removal from State permit. Page Dapartment of Important: If any injury or Culpeper National Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1/21/98 Culpeper, Virginia 21. Sign Manufof Juneral Service Users Brinsfield Funeral Home, P.A. Blankenship 22955 Hollywood ROad, Leonardtown, MD 20650 23a. Pert1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner and Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (of est a consequence of):

Obstver pulso ver

Due to (or as a consequence of):

)'Seme physician s the burial Physician/Medical attanding Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. signed by tha 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records, þ 24e. Wes en eutopsy performad? 24b. Were eutopsy findings eveileble prior to Completed peen Londogto Penin completion of cause of deeth? paga 2 cartificata 1 Yes 2 No Vital 25. Was case referred to medicel exeminer? diractor. Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o funaral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) To the Hospital or Attanding Privitin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division Neturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homloide 29a. Certifier Ecritifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted. Medical (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) DMM) 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

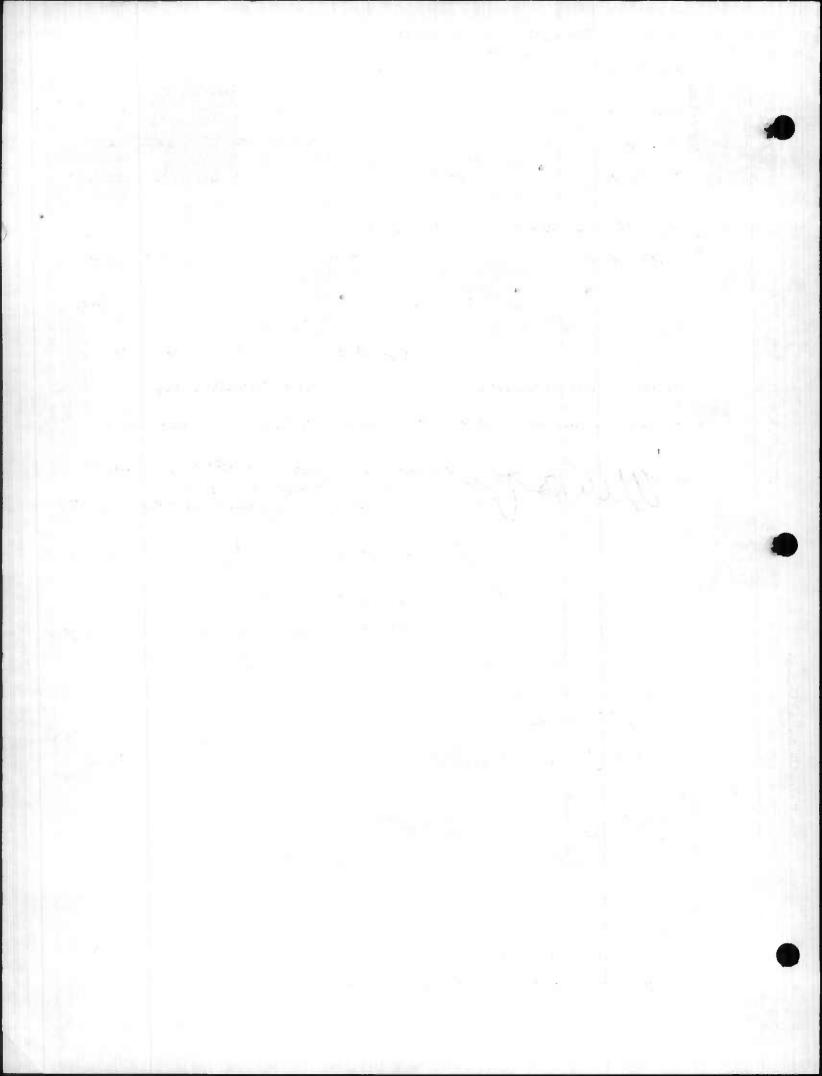
State Registrar

31. Dete filed (Month, Day, Yeer) JAN 21 1998

KIRAN D. MEHTA M.D.

PHILIP J. BEAN MEDICAL CTR. HOLLYWOOD, MD. 20636 32 Registrer's Signeture

THOMAS SULLIVAN



Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Vool KodMan Seese 7:14 1998 25/ 29 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Hay and U.
Sex 7. Age (In yrs. Baltanore If Under 24 Hrs. 8. D Hours Min. (A Medical Center rys. last birthday) If Under 1 iniversity Baltimore 8. Dete of Birth (Month, Dey, Year) 6. Sex Birthpleca (Stata or Foreign Country) 1X M 2□ F Months Deys Yrs 220-26-4135 July 29, 1926 Pennsylvania Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Caroline Denton 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 804 Camp Road 21629 United States Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Biack, White, atc. 11. Marital Status 1 Nevar Married 2X Married 1 ☐ Yes 2 ☒ No Specify. 3 Widowed 4 Divorced Caucasian 1946 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 HS Grad. Form Constructor Manufacturing 17. Fether's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) J. Seese Aura Patience Seeds Elmer 19e. tnforment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Betty C. Seese Wife 804 Camp Road, Denton, Maryland 21629 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 □Donation 5 □ Other (Specify) 1/25/98 Denton, Maryland Denton Cemetery of Funeral Service Lice 22. Name end Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellur. List only one cause on each line. Approximata Intervel Between Onsat end Death Immediate Ceusa (Final disaese or condition resulting in deeth) SEP513 10 days Due to (or es e consequence of): Organ Due to (or esta consequence of): ancreatitis Due to (or es e consequence of): Abdoninal Acrtic Aneurysis tured 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 □ Probably 4 Unknown Penpheral Vascular Discas 24b. Were eutopsy findings available prior to completion of causa of deeth? 24a. Was en eutopsy performed? 1 □ Yes 2 □ No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 28b. Time of

Physician /Medical Examiner

attending physician and for use as the burial-transit

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

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Completed

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Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mantal Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified... once.

Baltimore, Maryland 21215-0020

Examiner þ Be

been signed by the a should be datached t

To the Hospital or Attending Physician: The law requiras that the death certificate be assecuted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

Sequentiatly list conditions, if eny, leeding to immadiate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medicai Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Completed 25. Wes case referred to medicat examiner? 1 Yes 20 No Medical Certification: To 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending invastigation 1 Yes 2 No 2 ☐ Accident 3 Suicide 6 Could not be Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end piaca, end due to the cause(s) end manner stated. 29e. Certifier 29b. Signature and titia of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year)

22 S. Orcene Street, Balhuare, MD 21201

State Registrar

filled in by tha

completely

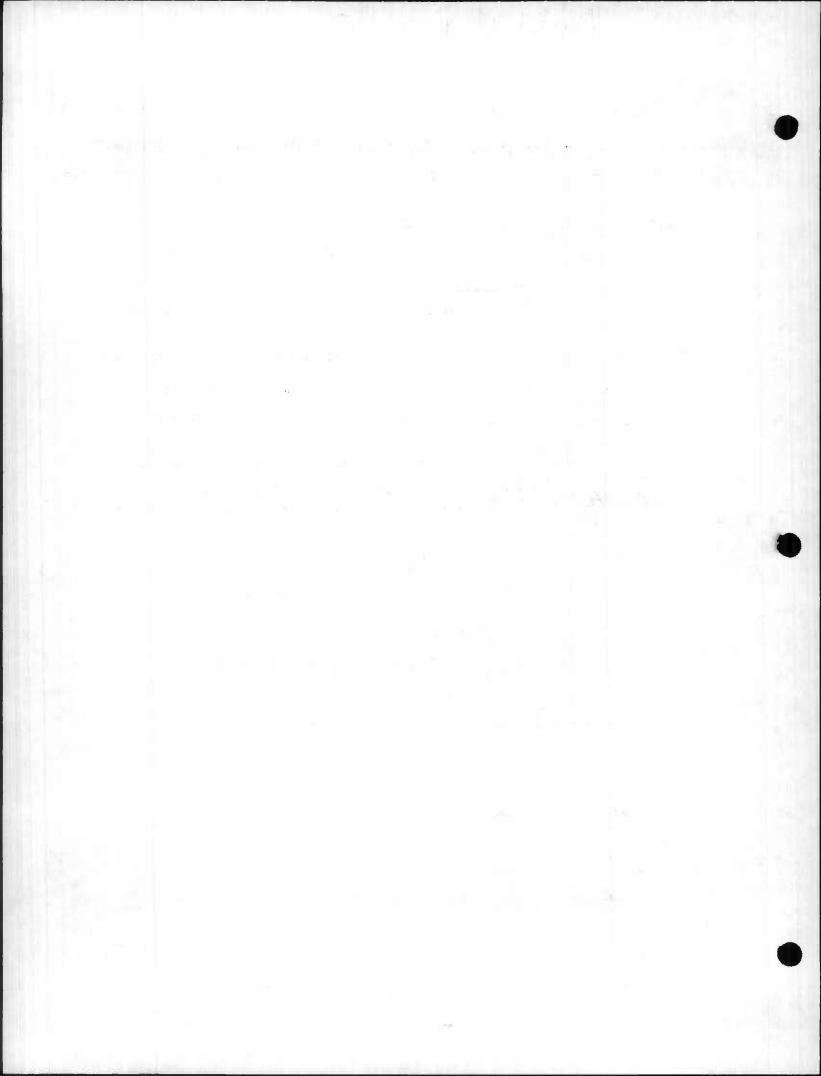
31. Data filed (Month, Day, Year) JAN 27

12ureen

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Burdett

- UD 22 32. Registrar's Signeture - Randale



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 98 4:05 pm Mary Elizabeth Robb Sparks 01 23 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Caroline Nursing Home, Inc. Denton Caroline If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Days Months 1 M 2 XF 78 Yrs. 186-16-0426 Pennsylvania Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2X No Maryland Caroline Greensboro 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12600 Greensboro Road 21639 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondery (0-12) College (1-4or 5+) grad llyrs seamstress manufacturing 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Robb Susan Burns Robb 19e. Intormant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Spicher daughter 12805 Kibler Road Greensboro, Maryland 21639 20b. Placa of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 Burlal 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/27 Greensboro Cemetery Greensboro, Maryland 21. Signature of Funeral Service Licansee 22. Name end Address of Facility Fleegle & Helfenbein Funeral Home, PA P.O. Box 160 Greensboro, MD 21639 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Acute a chronic disease or condition resulting in death) AQDIOVASCULAR Disease/chrone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events. Due to (or as a consequenca of): that initiated events resulting in death) Last Due to (or es e consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DISEASE/PREVIOUS C.V.A 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? KEZUMANT URINA 1 Tyes 2 No 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation

Examiner P.O. Box 68760.

physician and the burial-tran Se 950 Po signed by the aid be detached f peen certificate Division of Vital After this re Hospital or Attending in 24 hours after death. he Funeral Director: After coletely filled in by the fur To the Hosp within 24 ho To the Fune completely f

Physician

/Medical

Examiner

Directo

Funeral

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of Health Item 27

Physician /Medical

Examiner

Physician/Medical

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Completed

Be

2

Certification:

Medical

Pages nent of 9 Department of Important: If it any injury or o

25. Was case reterred to medical examiner?
1 ☐ Yes 2 No

27. Manner of Death Naturel 2 Accident

3 Suicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Gertifying Physician: To the best ot my knowledge, death occurred at the time, dete end piece, and due to the ceuse(s) end manner es stated.

28t. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and pleca, and due to the cause(s) and manner stated. 29b. Signature and title of certifler

29a, Certifier

29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and address ot person who cause of death (Item 23e) (Type, Print)

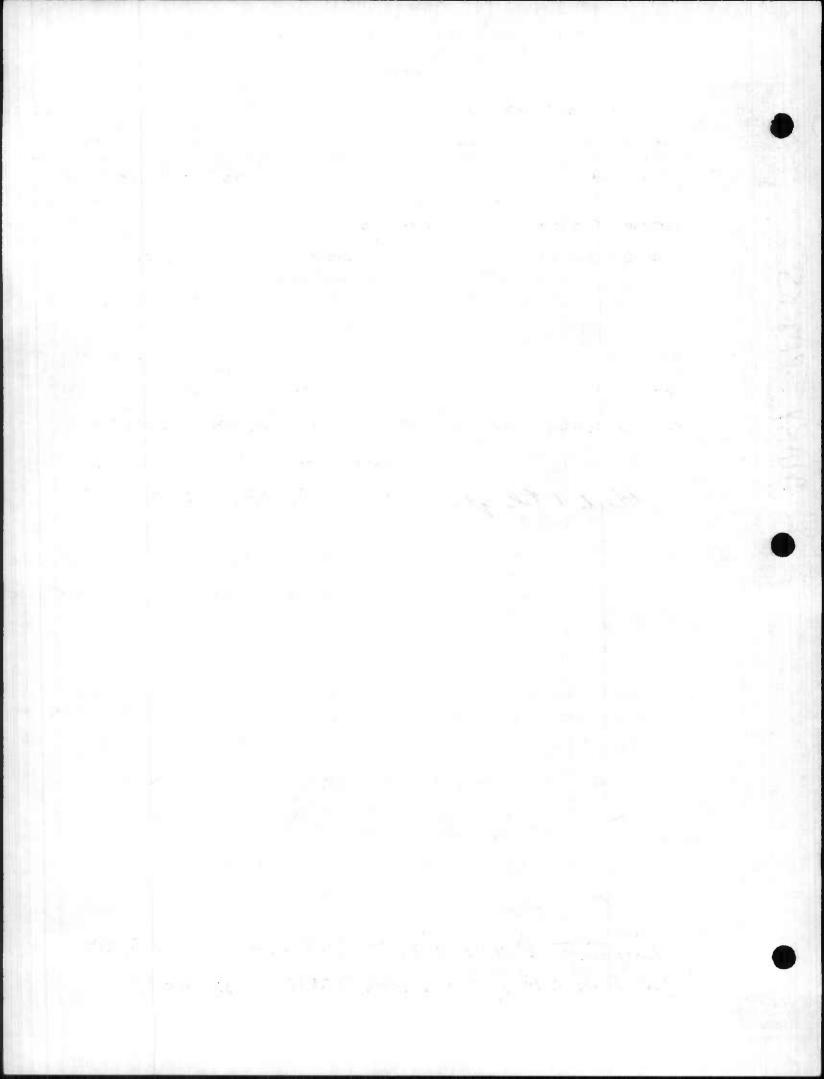
C.E. JENSEN Po Box 690 MO 31. Dete filed (Month, Day, Year)

DENTON MD 21629

State Registrar

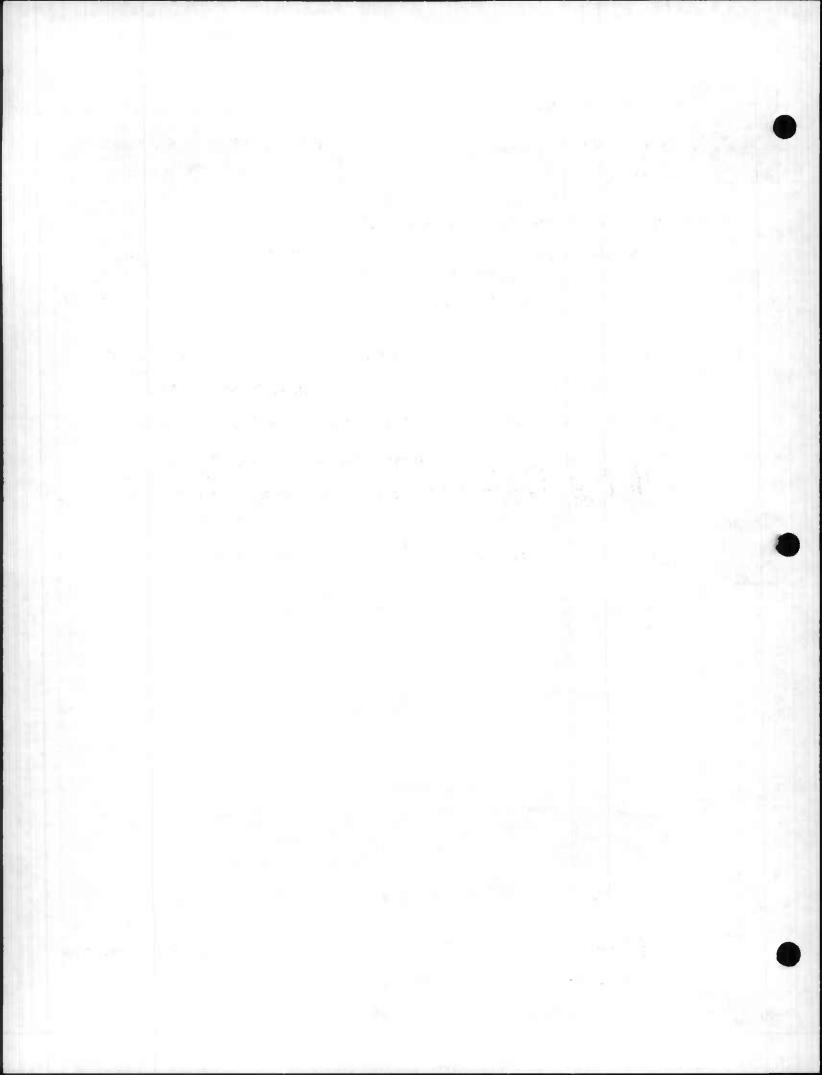
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32. Registrar's Signature was Devidson-Mandall



State of Maryland / Department of Health and Mental Hygiene

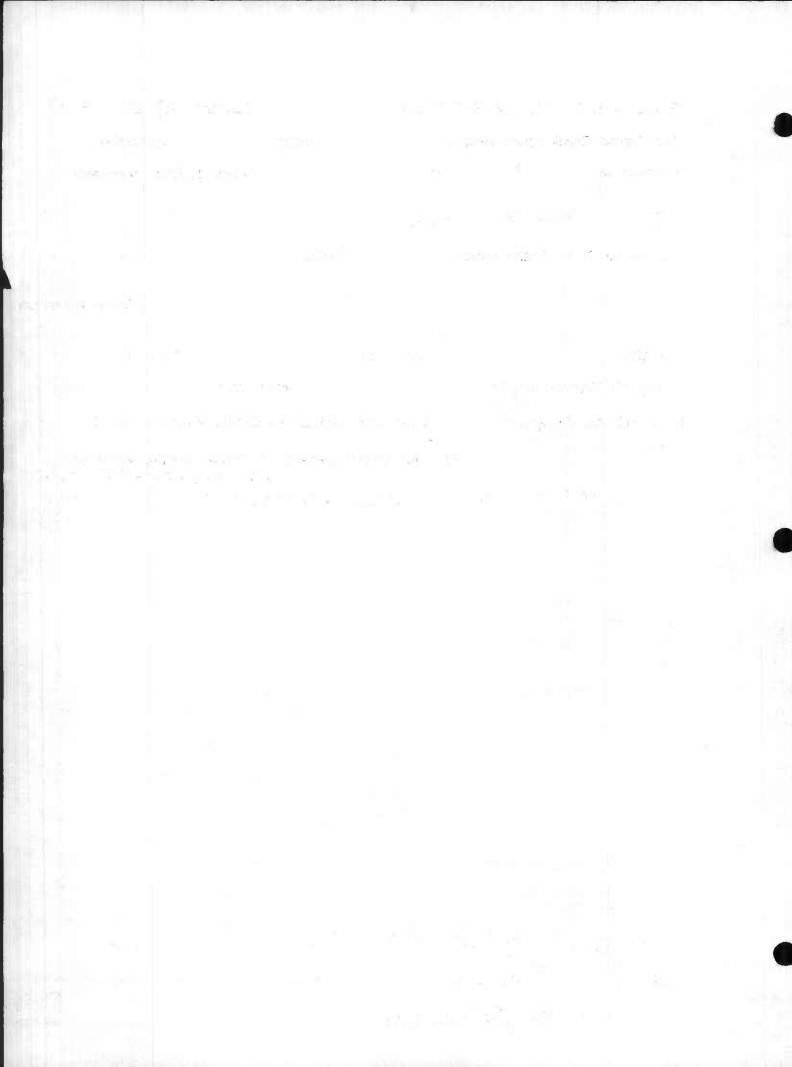
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Physici	an	1. Decedent's Name (First, Middle, Last WJ:LLTAM STALLM	•					2. Dete of Deetl Month	Dey Yee		
/Medic		4e. Fecility Neme (If not institution, give		1			4h Cihi Tours o	JANUARY Location of Deeth			
Examir	ner	30105 Shaw Court	The second secon						4c. County of De		
uneral		5. Sociel Security Number 6. S		ge (In yrs. le:	st birthday)	If Under 1 Yea	r If Under 24 Hr	csville	St. Mar	y S sirthplece (State or Fore	
irector			2 KM 2□ F	49	Yrs.	Months Deys	Hours Mir	Apr. 24	9. E 1948 Ma	ryland	
Mo to		10a. State 10b. County		10c. City,	Town or Lo	ocation				10d. Inside City Lim	
5	to	Maryland St. Mary	/'s	Mec	hanic	sville				1 □ Yes 2 □ I	
ns 23a or 28a-f show must be notified at	Funeral Directo	10e. Street end Number		1100	nun io.	10f. Zip Code		10	g. Citizen of Whet	Country?	
23a c	alD	30105 Shaw Cour	rt .				20659		USA		
or items	iner	11. Marital Status	12. Was Decedent Armed Forces?		. 13.	Was Decedent of	Hispenic Origin? (Specify Yes or No- rto Rican, etc.)	14. Raca - Ar Black, W	merican Indien,	
13	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 XYes 2 ☐ If Yes, Give Yeer or Dates	No		1 ☐ Yes 2 ☐XNo		nto I noati, oto.)	Specify:	White	
natural', adical Exa	Completed	15. Decedent's Ed	lucation		16e. Deced	dent's Usuel Occu	petion	autina 1	6b. Kind of Busines	ss/Industry	
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marked other than	Be	17. Father's Neme (First, Middle, Last)						ame (First, Middle, M			
natic evi	To	Alois O. Stallmar						Elizabeth			
7 is me traum	Agnes E. Stallma 20e. Method of Disposition 1 Burial 2 Cremation 3 4 Donetten 5 Other (Spec									a, Zip Code)	
am 27 other tr			I-MOCHET	20b. Ple		sition (Neme of metory or other pla			2000Z	or Town State	
y or o											
Important: I any Injury o once.			0	St.	-	r's Ceme		1-21-98 V	0. Box 1		
any fr		Mark Brohawn	M00053	un						20604-015	
		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	olications thet cause one cause on each li	d the deeth.	Do not ent	er the mode of dy	Ing, such es cardi	ac or respiretory erre	st,	Approximete Interval Between	
slcian										Onset end Deeth	
ledical aminer		Immediate Ceuse (Final disease or condition resulting In death)	· CAM	CER	- 0	PE:	SOPHF	ICUS		2 WK	
	<u>-</u>			Due to (or e	es e conseq	quence of):					
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in and	Еха	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or e	es e conseq	juenca or):					
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as th	Medical	resulting in deeth) Lest		Due to (or a	is a conseq	delice oi).					
attendin for use			d		-						
the atte	sicie	Part ff. Other eignificant conditione co	ontributing to death b	out not resulti	ing in the u	nderlying cause g	iven in Pert I.	23b. Did tol	Dacco usa contribu	ita to the causa of de	
aco	Physiclan/							1 🗆 Ye	8 2 No 3	Probably 4 Unkr	
igned be dat	by							-		, \	
been si should	Completed							24a. Was er perform		 Were eutopsy finding evailable prior to 	
SCA	nple									completion of cause of death?	
peg.	ပ္ပ							1 □ Ye	s 2 No	1 ☐ Yes 2 ☐ No	
s cartificate ha	Be	25. Wes case referred to medical examiner?	Hospital:					eath (Check only one	9)		
£ 700	To To	1 Yes 22 Yo 27. Megner of Deeth	1 LI Inpatie		R/Outpatien			Home 5 Assider		pecify)	
After	tion	→ Natural 5 Pending	28e. Dete of Inju (Month, De	y Year)	Injury	W	ork? ☐Yes 2☐No	28d. Describe ho	w injury occurred		
Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be		iury - At hom	e ferm str	eet, fectory, office		28f. Location (Str.	eet end Number or	Rural Route Number,	
Dire	erti	4 ☐ HomicIde determined	building, et	c. (Specify)	,,	out, routory, omoc		City or Town,			
To the Funeral Director: A completely filled in by the to	edical C	29e. Certifier (Check only one) 2 Medical Exam	ilner: On the basis of	f exeminetion	edge, death	occurred et the t vestigation, in my	ime, date end plac opinion, deeth occ	ca, end due to the ca curred et the time, de	use(s) end menner ite end place, and d	es steted. ue to the ceuse(s)	
o the	Mec	29b. Signature end title of certifier	end menner st	e(eg.		29c. Licer	ise number	20	d. Dete signed (Ma	nth Dev. Year)	
5 5		1 socies	1	7.0							
		W TOWN	1 C.	1000	~~		8352	JA	NUARY 1	9,1998	
			completed cause of d	teath (Item 2	3a) (Type.	Print)					
		30. Name and address of person who of KRISHAN MATHUR					A DI Ama	MD 20	646		



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Deeth 1. Decedant's Nama (First, Middla, Last) 3. Time of Death Month Yaar **Physician** 07:57 BEULAH BRITTINGHAM SHOCKLEY 1998 January /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 545 Trappe Creek Apartment, #2 Berlin Worcester 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Aga (In yrs. iast birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 200 F Days Hours Yrs. Director 215-76-2764 March 1, 1926 Maryland Usual Rasidanca of Dacedani 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at WORCESTER 1 ☐ Yas 2 No Director Berlin 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 545 Trappe Creek Apartments, #2 21811 USA 12. Wes Decedent Ever In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Ricen, etc.) 14. Race - American Indian Black, Whita, etc. 1 ☐ Yas 2X No If Yas, Giva 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: African American þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7. Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Mean 2016. Elementary/Secondary (0-12) Collaga (1-4or 5+) 6th grade domestic housewife 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surname) Benjamin Brittingham, Sr. Mary Ayres 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) Ida Brittingham/daughter 10803 Redwood Lane - Berlin, Maryland 21811 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cramation 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Other (Specify) St. Paul Church Cemetery 01/14/98 Berlin, Maryland 22. Name end Addrass of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Funaral Sarvice Licenses JOLLEY MEMORIAL CHAPEL 21801 23a. Pert1. Enter the disaasa, or complications that caused the beath. Do not enter the mode of dylng, such es cardiec or raspiratory errast, shock, or Jean failure. List only one cause on each line. Approximate Interval Batwe Onset end Death **Physician** /Medical Immedieta Causa (Final disaasa or condition resulting in daath) ACUTE ASTHMATIC MITACK FEW HOURS Examiner Dua to (or as a consequence of): MANY YEARS BRONCHIAL ASTHMA attending physicien and for use es the buriel-transit that the death certificate be executed Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): P.O. signed by the sid be deteched to Pert II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to Completed 24a. Was an eutopsy complation of ceusa of death? page 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

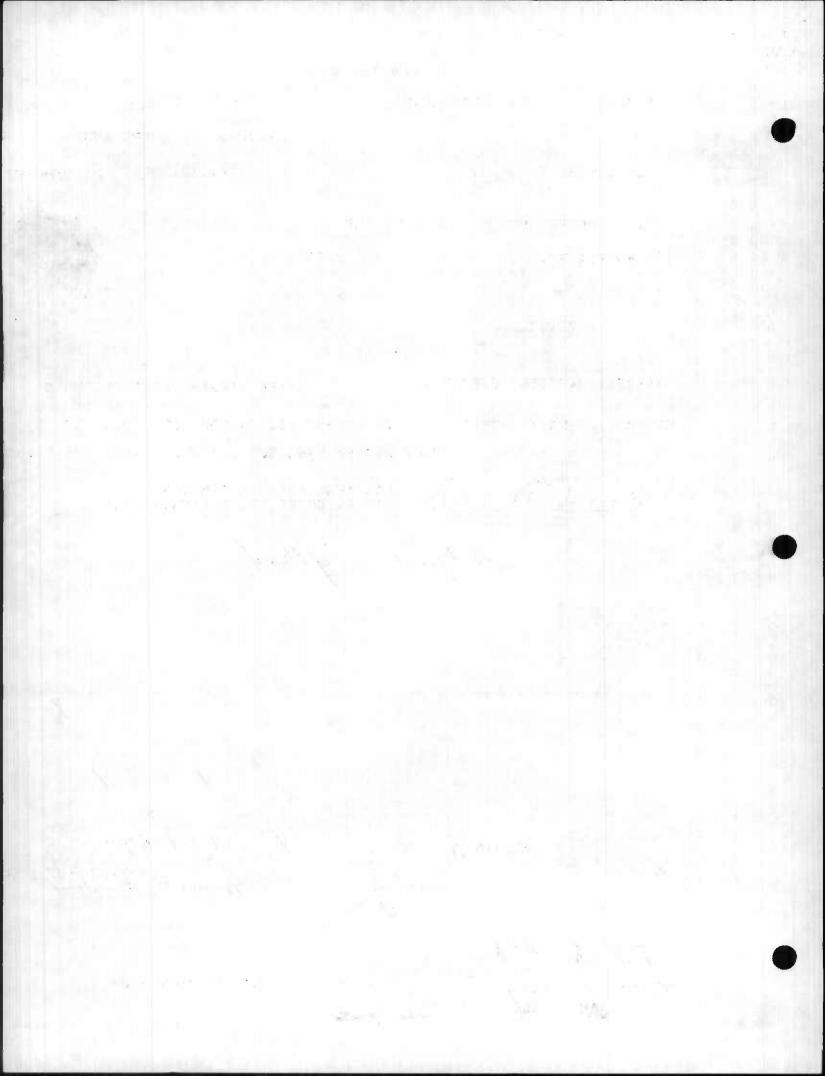
To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Wes case rafarred to medicel 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 70 12 Yas 2 No 28c. Injury at Work? 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: 28b. Time of 5 Panding Invastigation 1 Naturel 1 ☐ Yas 2 ☐ No 2 Accident 3 Sulcida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the ceusa(s) and manner as steted.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and place, end due to the ceuse(s) and manner stated. 29a. Certifiar Medical 29b. Signature and titla of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) Arbunt 006241 1-15-98 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) 203 SNOW ST. Six HILL MD. 21863 HOLZWOZTH M.D. DOROTHY 31. Deta filed (Month, Day, Year) 32. Registrar's Signetura State Alli Stevelen Randall Registrar JAN 2 0 1998



State of Maryland / Department of Health and Mental Hygiene

π.ν			Certificate of		Reg. No.	0 0 1 50				
Physician /Medical		EITH TILGH	IMAN			3. Time of Death 8:30 PM.				
Examiner	4e Facility Neme (If not institution, gir 4819 MAIN ST			4b. City, Town, or Loca GRASONVI	LLE QU	DEEN ANNE				
Funeral Director	212-94-1104	Sex 7. Age (In yrs. 32	last birthday) If Under 1 Yes Months Day	r If Under 24 Hrs. 8 S Hours Min.	Dete of Birth (Month, Day, Year) EB • 13,19	9. Birthplace (State or Foreign Country) BALTIMOR				
Hed at	Usual Residence of Decedent 10a. State 10b. County MD • OUEEN		y, Town or Location			10d. Inside City Limits 1 1 Yes 2 □ No				
3a or 28a-f at be nouth	10e. Street and Number 124 FOREST RD		10f. Zip Code	638	10g. Citize	n of What Country?				
al, or tems 23s or 28s-1s Example: noutled by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Hispanic Origin? (Spec ben, Mexican, Puerto Ri	ify Yes or No- can, etc.)	Race - American Indian, Black, White, etc. pecify: BLACK				
Ngiene. ner than "naturn nt, ir executed Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's Usuel Occ (Give kind of work don life. DO NOT use reti	upation e during most of working red)		of Business/Industry DSCAPE				
d out	17. Fether's Name (First, Middle, Last HERBERT GARF				First, Middle, Maiden Su					
7 is marke traumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,									
ment of Heal ant: If Item 2 ury or other	HELEN TILGHMA 20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special Control of Special Control of Control of Special Control of	Removal from State UN	124 FORE Place of Disposition (Name of conserver or other property of the prop	CEMETERY	Dete 20c, Loca	C, MD. 21638 tion - City or Town, State STEVENSVILLE,				
ysician Medical aminer	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line.	DASHIEI 319 E. n. Do not enter the mode of d	L FUNERAL DOVER ST.	EASTON, M	ID • 21601 Approximate Interval Between Onset and Death				
iding physicien end isse es the burist-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (o	r as a consequence of): r as a consequence of): r es e consequence of):							
ed by the etten deteched for u	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying cause	given In Part I.	23b. Did tobacco us	se contribute to the cause of death? No 3 Probably 4 Unknown				
hes been sign je 2 should be mpleted by					24a. Was an autopsy performed?	eveileble prior to completion of cause of death?				
certificate he rector, page	05.14				1 Yes 2	No Yes 2□ No				
s certific director,	25. Was case referred to medical examiner? 1X Yes 2 No	Hospital:	500 A-10-1 20 00A	26. Place of Death		Wother (Specify) AT				
h. After th funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	28a. Date of Injury (Month, Day Year) 10 11 128a. Date of Injury (Month, Day Year) 128a. Place of Injury - At he	28b. Time of Injury 28c. In W	jury at / Yes 2 XNo	Bd. Describe how injury of the factor of the	Number or Rural Route Number,				
	29a. Certifier 1 Certifying Pl	hysician: To the best of my kno	welling wiedge, death occurred at the							
the Funer pletely fill	(Check only 2 Medical Example)	niner: On the basis of examina and manner stated.								
To the com	29b. Signeture end title of certifier	4Kin -		o.C.M.E.		signed (Month, Day, Year) 07, 1998				
	30. Name and address of person who	completed cause of seath (Item	123a) (Type, Print) 11 Penn Street	t, Baltimore	e, Maryland	21201				

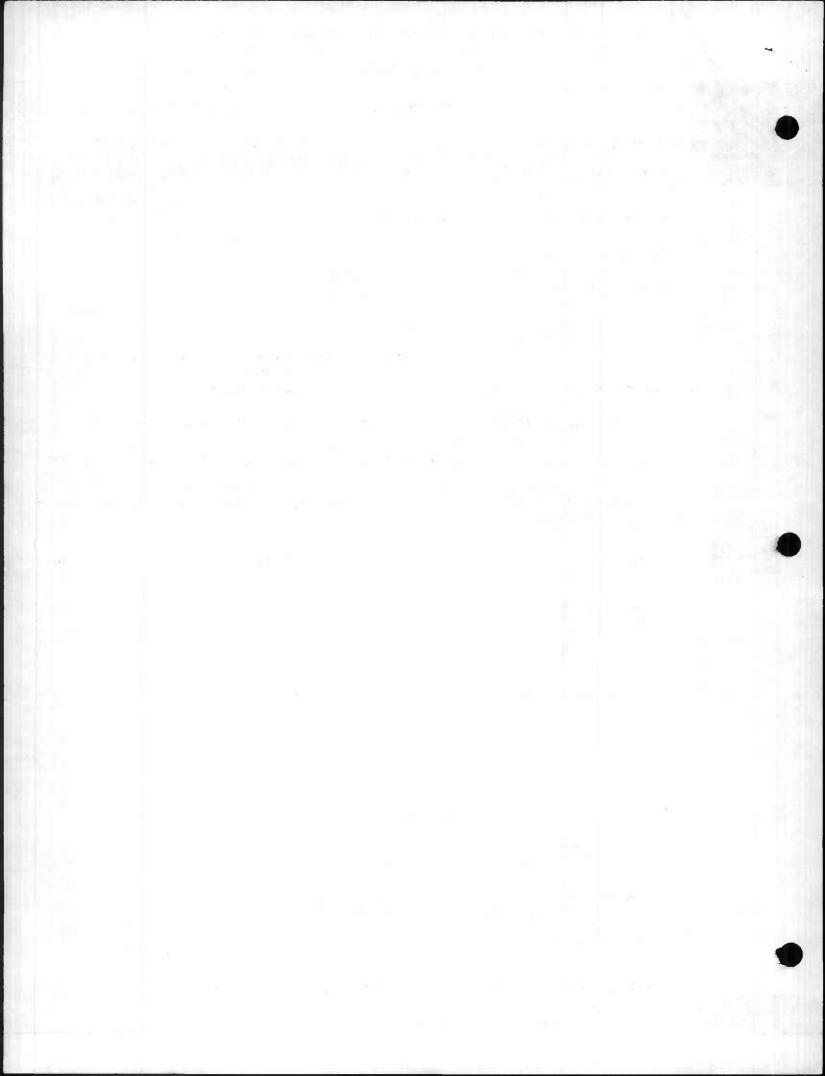
State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death

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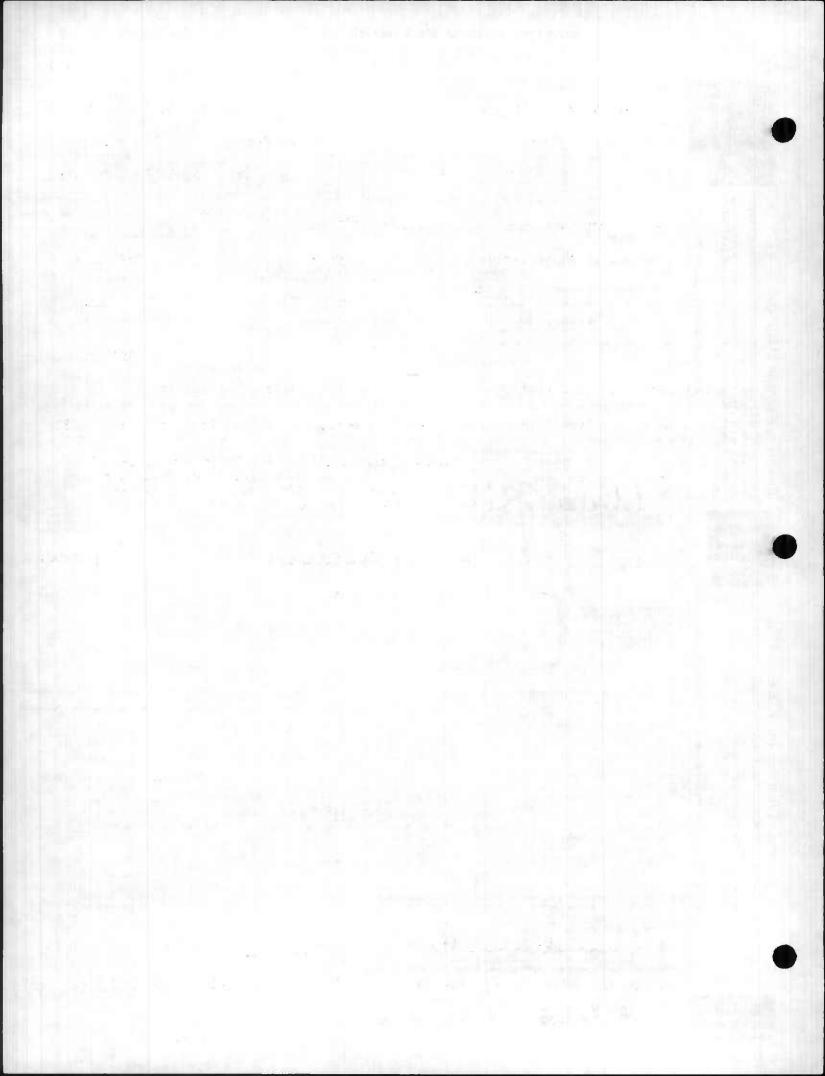
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	/Medi Exami		4e. Fecility Neme (If not institution, give	straat and number)		CIII OII	IIIIIIA,	4b. City, Town, o				0.14 AM
	Exami	101	HOLY CROSS HOSPIT	AL				SILVER	SPRING	MONTO	GOMERY	
	Funeral		Social Security Number 6. Security Number	9X 7. Ag	e (In yrs.	lest birthde	y) If Under 1 Ye					ace (Stete or Foraign
	Director		579-50-5767 Usuel Residence of Decedent	X M 2□ F	60) Yrs.	Worths	ys riodis iviii	Feb 7,	1937	Washi	ngton, DC
	72 hours efter death with the Marylend natural, or Hems 23a or 28a-f show areal Examiner must be notified at		10a. Stete 10b. County		10c. City	y, Town or	Location				10	d. Inside City Limits
	e Ma	ctor	Maryland Montgom	ery	S:	ilver	Spring					1 ☐ Yes 2 ☐ No
	1 th	Director	10e. Street and Number				10f. Zip Cod	е		10g. Citizen of	Whet Countr	y?
	ath w		12325 La Plata St					904		USA		
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forcas?		S. 1	Was Decedent of If Yes, specify C	of Hispanic Origin? (Juban, Mexican, Pue	Specify Yas or Norto Rican, etc.)	0- 14. Red Ble	ca - America ck, White, at	
20	ours ofter death with the Manyler al, or items 23a or 28a-f show Examiner must be notified at	by F	1 ☐ Naver Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XI If Yes, Give Yeer or Detes:	Vo		1□ Yes 2□XI	No Specify:		Specif	y: 5.71	
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Var	end end s m		19a. Informent's Name/Reletionship (7	, , , ,			_	eet end Number or I				
e,	of Health litem 27 l		Carolyn Tranchite	lla/Wife	Jack D			ata St, S				
Baltimore, Maryland	5 5 5		20a. Method of Disposition 1 ↑ Burlal 2 □ Cremetion 3 □		C	emetery, c	position (Neme of remetory or other	p/ece)	Dete	20c. Location		
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	Physician /Medical		Immediate Ceuse (Finel									
	Examiner		diseese or condition resulting in death)					Infarction	n			Minutes
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	eath certificate be executed ettending physician and for use as the buriel-transit	Examiner	Sequentially list conditions.	b	Due to (or	r es e cons	sequence of):					
0,	e exe		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury								İ	
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n	ng Ph fter th ineral		27. Menner of Deeth 1 XNeturel 5 ☐ Pending	28e. Dete of Inju (Month, Day	Year)	28b. Time Injury	of 28c. I	njury et Vork?	28d. Describe	how Injury occur	rred	
sio	Attending r deeth. octor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be					I ☐ Yes 2 ☐ No				_
Division of Vital Records,	To the Hospital or Attending I within 24 hours efter deeth. To the Funeral Director: After completely filled in by the funeral process.	Certification:	4 ☐ Homicide determined	28e. Placa of Inju			street, fectory, offi	ce		(Street end Numi own, Stete)	ber or Rurei	Houte Number,
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			1 Name (14	sury M.D.			D	40279		1/14/	44	
	10		30. Neme end eddress of person who c	1	eeth (Item	23e) (Typ		,		1.1	-	
			Daniel V. Young	4910 Mass	sachu	sett	s Ave, N	W, Washing	gton, DC	20016		
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State of Maryland / Department of Health and Mental Hygiene

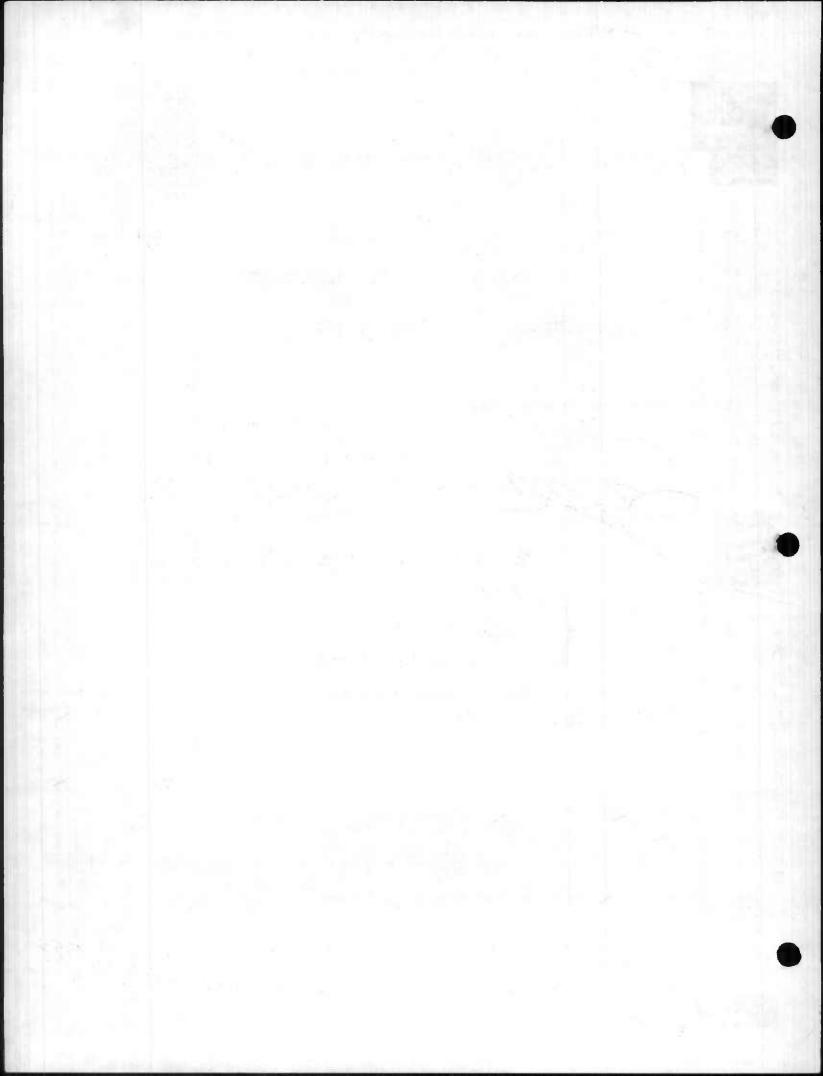
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	Physicia: /Medica		Mary Virgin	ia Thoma	s						Januar				8:25 PM
	Examine	_	4a Facility Neme (If not institution, gi	ve street and nun	nber)				4b. City, To	wn, or L	ocation of Deat	h 4c.	County of	Death	
			Manor Care - Wh	eaton				S	ilver	Spi	ring		Mont	gom	ery
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	and and		10a. State 10b. County		10c. City,	Town or Lo	cation							1	Od. Inside City Limits
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	Hygiene. ther ther	ပ္ပံ	12			Cle	erk						Gover		nt
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Z a	should be formal in marked or urmatic eve	0	James Walter Pu								Jane Wa				
Maryland	2 0 1 0		19a. informant's Name/Relationship								rel Route Numb				o Code)
-	of Health of Health If item 27 i	-	Mary Jane Gray	(daugh			Indep		lence	Stre	Date Roc		lle,		20853
0	Pages 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 l	☐Removal from S	State	metery, crer	natory or oti	her ple							
H		1	4 □ Donation 5 □ Other (Spec	• •	Park		Memor				/19/98				
Baltimore,	permit Pa Department Important: any injury		21. Signature of Funeral Segrice Lice	, Q-C	le	Ho	ome. I	nc.	500	Uni	ancis l versity 20901				uneral
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that co	bused the death.	Do not ent	er the mode	of dyl	ng, such as	cerdiac	or respiretory a	arrest,			Approximate interval Between
	Physician			V											Onset end Death
	/Medical Examiner		Immediate Cause (Final disease or condition	a Bra	in	me	tas	to	ai	1				- 1	I week.
	CATEMATOR !		resulting in death)	G. 1P	Due to (or	as a consec	(as)							1	week 5 months
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Box	that the death cered by the attendir	by Physician/													
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of Vital Records,	8 50	2									24e. Wes	en euto	DEV	24b. W	/ere autopsy findings
Ö	v require been si should	Completed									perfe	ormed?	poy	av	vailable prior to ompletion of cause
3ec	2 2 3	E E													death?
<u>e</u>	: The cate h										10	Yes 2	No	1	☐ Yes 2四 No
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of	this caldir	2	1 Yes 2 No	1 1 1		R/Outpatier		A		ursing H	ome 5 Res				ify)
- L	ulng Phys	0	27. Manner of Death 1 Natural 5 □ Pending		of Injury h, Day Year)	28b. Time or Injury	M	Bc. Inju Wo	rk?]Yes 2□	Mo	28d. Describe	now inju	ry occurre	u	
Si	Attending ir death.	cat	2 Accident Investigation 3 Suicide 6 Could not	00	-6.3-1. 0.0				1165 2	140	20f Location	/Cimata	nd Alumba	r or Pur	ral Route Number,
Division	or At effer Direc	Certification:	4 Homicide determined	200. Place	of Injury - At honing, etc. (Specify)	ne, tarm, str	eet, factory,	, OTTICE			City or To			r or nur	ar noute rumber,
	To the Hospital or Attending Phywithin 24 hours effer death. To the Funeral Director: Affer thi completely filled in by the funeral	Cal	29a. Certifier (Check only 2 Medical Exa												
	in 24 the Fi	edicai	one)	and manr		JI AIIWOT IN				Jan Oocul	ros at the time,				
	To t To t	Σ	29b. Signature and title of certifier	0.0	ma				se number			29d. Da	ite signed	(Month,	Day, Year)
	10		meno	ellen	que		D	3	826	5 2	_	71	+N	19	, 1998
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia	an l	1. Decedent's Nam			THORNE	C				2. Dete of De Month	09 ^{Day} 19	OYear	3. Time of Death
/Medica	al	4a. Facility Name (/				5			4b. City, Town, or				18:05
Examine	er	, , , , , , , , , , , , , , , , , , , ,	Wash:	ington	Adve	ntist	Hosp	oital	Takoma	Park	PG		
Funeral Director		5. Social Security N 241-14-	9347	8. Sex 1 ☐ M 2	7. Age	(In yrs. last bi		Under 1 Year onths Deys	if Under 24 Hrs Hours Min.		1920	9. Birthple Coupt	ace (State or Foreig
ž u	1	Usual Residence of 10e. Stete	Decedent 10b. County		1	10c. City, Tow	vn or Location	n				10	d. Inside City Limits
and sh	tor	MD		PG		Lar	go						1 XYes 2 □ N
23a or 28	al Director	10e. Street and Nur		Norwo	ood Co	urt	10	of. Zip Code 2 (774		10g. Citizen of 1	What Count U.S.	ny?
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and Mental Hygiene. Is marked other than sumatic event, ir	Be Co	17. Fether's Name (Last)					18. Mother's Na	me (First, Middle	, Ma <i>id</i> en Suman		
Menta arked atic ev	ToB		Jim (N	Minnie	Pearso	n	
Health and em 27 Is m other traum		19a. Informant's Na			m)(grands Chomas		b. Mailing Add		and Number or Ri d Ct I	ural Route Numb			Code)
0 = 0		20e. Method of Disp 1 X Buriai 2 (4 ☐ Donation	☐ Cremation		il from State		of Disposition ery, crematory Ony M		al Park	Date 1-16-	20c. Location -		m, State
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ysician Medicai aminer papal-tagas papal-tagas papal-tagas	Medical Examine	23a. Part1. Enter the shock, or had shock, or had shock, or had shock, or had shock, or had shock, or had shock and	Final nditions, mediate rlying injury	a. M. S. S. C. G.	Degsis augun	ue to (or as a	382 not enter the	Lailung Lailung Lailung Lailung Lailung Lailung Lailung Lailung Lailung	e with	c or respiratory	rrest,		Approximate Interval Between
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	and w		10e. State	10b. County		10	c. City, Town or	Location					10d. I	nside City Limits	
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	the 28a	Director	10e. Street end Nu	mber			-	10f.	Zip Code			10a. Citizen of	Whet Country?		
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3-00-6	fled within 72 hours after death with the Maryland Hygiene. ther than "netural", or items 23s or 28s-f show ent, the Medical Examinet must be notified at	Completed	10	15. Decedent's Ed			16e. Dec	edent's U	suel Occu	petion		16b. Kind of E	Business/Industr	у	
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	centificate be executed ding physician and use as the buriel-transit	Ca	thet initieted events	S	c	Due	to (or es e conse	equence o	f):						
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ממ	endir use	2			d	_									
	death e atter	sicie	Pert II. Other eignit	ficant conditions o	ontributing to d	death but no	ot resulting in the	underlyin	g ceuse gi	iven In Pert I.	23b, Did	tobacco use co	ontribute to the	cause of death	
,	that the	Physician/M	Arterio	losclerot	ic Card	diowas	cular D	icas	20		10	Yes 2 No	3 Probably	4 Unknow	
ń	v requires that the death certifics been signed by the attending pl should be detached for use as t	by	MI CCI IO	IOSCICIOE	ic oait	TTO VAL	culai b	Toca.							
colds,	requires seen sign should be		Hyperto	ension							24e. Wes	en eutopsy rmed?	24b. Were e evelleb	utopsy findings le prior to	
ני	2 5 2	ple				-							comple of deeti	tion of ceuse	
5	0 - 0	Completed	Atrial	Fibrilla	tion						10	Yes 2X No	1 □ Ye	s 2 No	
	certificate	Be C	25. Was case refer	rred to medical						26. Plece of Deet	h (Check only o				
> :	Physician: this certific ral director,	10	examiner?	No	Hospital: 1 🗆	Inpatient	2 ER/Outpati	ent 3	DOA Ot	ther: 4 Nursing Ho	me 5X Resi	dence 6 DOt	her (Specify)		
5	ding Ph h. After th funeral		27. Manner of Deet		28a. Dete	of Injury oth, Day Ye	ar) 28b. Time		28c. Inju Wo	iry at	28d. Describe	how Injury occu	rred		
	Attending or death. actor: After by the fune	atic	1 XNeturel 2 ☐ Accident	5 Pending investigation	1	, 22, 12	,,	M		Yes 2□No					
<u> </u>	or Attending a ster death. Diractor: Af in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. PIEC	e of Injury -	At home, ferm, s	treet, fact	ory, office		28f. Location (- City or To		ber or Rural Ro	ute Number,	
	rs afte	Cer													
	4 hour	edical	29a. Certifier (Check only	Certifying Ph	ysician: To the	e best of my	knowledge, dee	th occurre	ed et the ti	ime, dete end place, opinion, deeth occur	end due to the	cause(s) end m	enner es steted	ceuse(s)	
10	To the Hospital or within 24 hours after To the Funerel Dirac completely filled in the		one)		end mer	ner stated.							_		
-	To To	Σ	29b. Signature end	title of certifier	Mis	unh	D	2		se number		29d. Date sign	ed (Month, Dey,	Year)	

4900 Massachusetts Ave NW

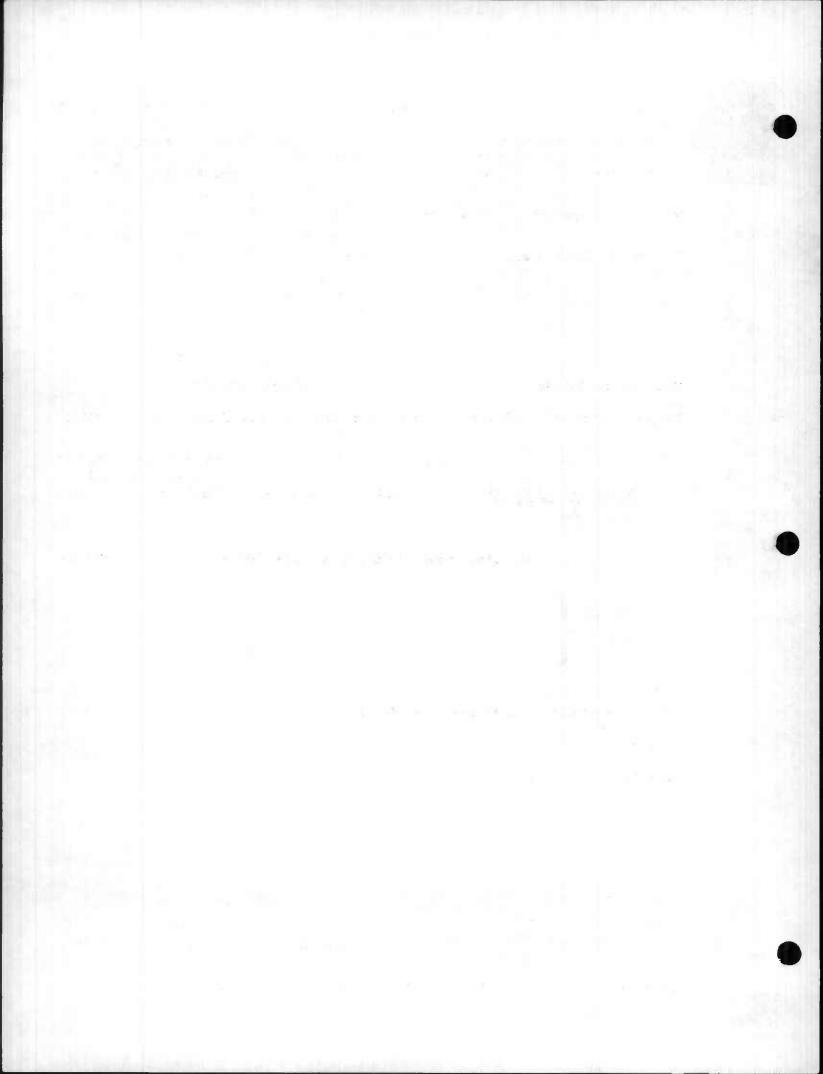
Washington, DC 20016

Registrar

State

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Jerry A. Snow MD., 31. Dete filed (Month, Day, Year) JAN 21 1990



Please

	Plea		Print In Black								200	ble.		Free
		State	of Maryland / D				Health a Death		fental Hy	gien Reg. N		8 (287	7
Decedant's Nan	na (First, Midd	la, Last) FRAN	K MELVIN	TIP	TON		1		2. Data of Da Month JAN .		ay 19	Yaar 98	3. Tima of 1:00	
		n, giva streat and no R AVE.	mbar)						ocation of Deat	h 4		of Death		
5. Social Security 4 1 3 - 5 0 -	6352	6. Sax 1 M 2 □ F	7. Aga (In yrs. last birt		If Under 1 Months	Yaar Days		24 Hrs. Min.	8. Data of Bi (Month, De 9/19	th ay, Year 19			laca (Stata or try) IESSEE	
Usual Rasidanca o	of Dacedant 10b. County		10a Ciby Taum	1	Man									
MD.		ROLL	10c. City, Town									1	0d. Inside Cit 1 ∰ Yas	
10e. Street and Nu	imber				10f. Zip C	oda				10g. C	itizan of	What Cour	try?	
111 SH	AEFFEI	R AVE.			211	57				US	Α.			
11. Marital Status 1 Nevar Mar 3 Widowed	ried 2⊠ Mar	ried Armed F	2□No 1954		s Deceda as, specif	-		gin? (Sp n, Puarto	ecify Yas or No Rican, atc.)	>-		ce - Amaric ck, Whita, y: WH		

29d. Data signed (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examinet must be notified at once. Baltimore, Maryland 21215-0020

Physician /Medical

Examiner

Funeral

Director

29b. Signatura and titla of certifiar

31. Data filad (Month, Day, Year)

MAGAN PANSURIYA, MD

JAN 2 0 1998

Manshiga my

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

32. Registrar's Signatura

Director

Funeral

by

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the lunearial director, page 2 should be deteched for use as the burlet-transit one pietely filled in by the lunearial director, page 2 should be deteched for use as the burlet-transit Medical Certification: To

Division of Vital Records, P.O. Box 68760.

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lo pe combleted	15. Dacedant's Edu (Specify only highast grad		16a. Decedant's Usual Oc (Giva kind of work do lifa. DO NOT usa ra	orking	16b. Kind of Businass/Industry			
E	Elamantary/Sacondary (0-12)	Collaga (1-4or 5+)	CARPENT			CONST	RUCTION	
000	17. Fathar's Nama (First, Middla, Last)			lama (First, Middla, Maiden Sumama)				
3	FRANK	TII	PTON	FRAN	CIS L. I	. LITTLEJOHN		
	19a. Informant's Name/Ralationship (7)	vpe, Pnint)	19b. Mailing Addrass (Str	eet and Number or R	ural Routa Number	nber, City or Town, Stata, Zip Coda)		
	SHIRLEY J. TIPT	, MD. 21	157					
	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ f 4 ☐ Donation 5 ☐ Other (Specify)	Ramoval from Stata	Place of Disposition (Nama of cematary, cramatory or other CHANY CEMETI	piace)			City or Town, Stata	ſD.
	21. Signature of Fungral Service Lipens	this		drass of Facility F:				157
	23a. Part1. Enter the damasa, of comp shock, or heart febure. List only o	lications that caused tha deal na causa on each line.	th. Do not antar the mode of	tylng, such as cardia	rast, Approximata Interval Batween Onsat and Death			
	Immediata Causa (Final disaasa or condition rasulting in daath)	septi	cemia				INI	人
	rasulting in daath)	2w	Bs					
	Sequantially list conditions, if any, leading to Immediate causa. Enter Underlying Causa (Disease or injury	Adence	or as a consequence of):	19 04	lung	_	60	Maron
	that initiated avants resulting in death) Last	Dua to (c	or as a consequance of):			7		
	Part II. Other significant conditions co-	ntributing to death but not ras	culting in the underlying cause	givan in Part I.	23b. Dld to	obacco uae cor	tribute to the cause	of death?
	Supravento	ichlar t	achicar	250	124	es 2□ No	3 □ Probably 4	Unknown
	chronic of				24a. Was a perform		24b. Wara sutops available prio completion o of death?	rto
					1□ Y	as 200 No	1 □ Yas 2	□No
	25. Was casa rafarrad to medical axaminar?	danatai.			ath (Check only or	(a)		
-	1 Vas 2 No Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 DO							
	27. Mannar of Death 1 Natural 5 Panding 2 Accident invastigation	28a. Data of Injury (Month, Day Year)	(ear) 28b. Tima of Injury at Work? M 28c. Injury at Work? 1 □ Yas 2 □ No					
	3 ☐ Sulcida 6 ☐ Could not be 4 ☐ Homicida datarminad	28a. Placa of Injury - At h building, atc. (Spaci	oma, farm, straat, factory, offi	Ce .	28f. Location (Si City or Town		er or Rural Routa Nu	mber,
	29a: Cartifiar (Check only one) 1 Certifying Phy 2 Medical Exami	sicien: To the best of my kno ner: On the basis of axamine and mannar stated.	owladga, daath occurred at the tion and/or invastigation, in m	tima, data and plac y opinion, daath occ	e, and dua to tha c urred at tha tima, d	ausa(s) and ma ata and placa, a	nnar as stated. and dua to tha cause	n(s)

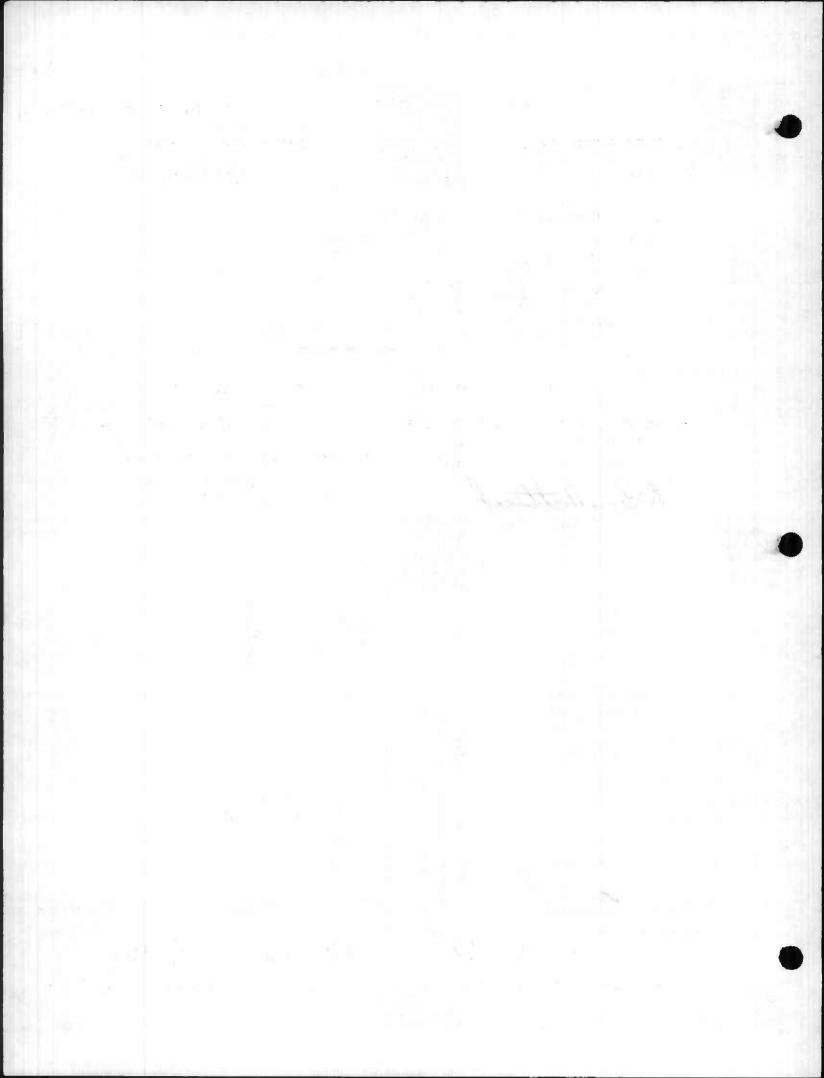
29c. Licansa number

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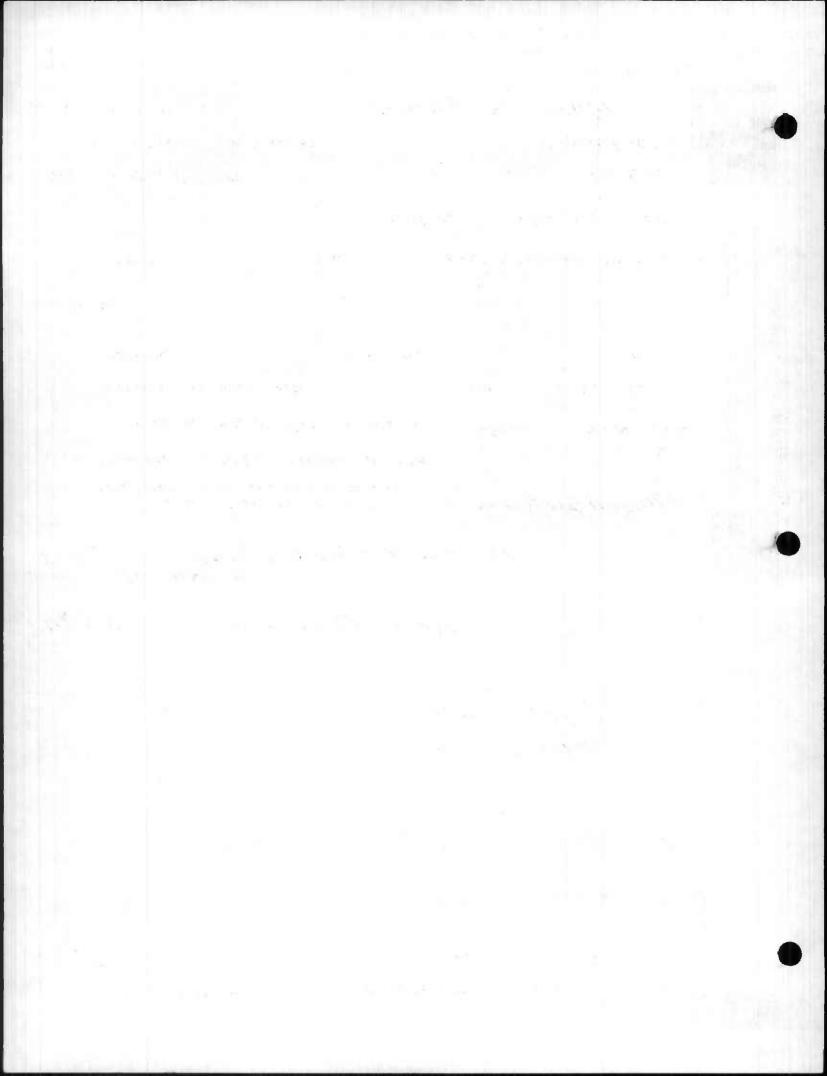
1363 N. Main St., Suite #3, HAMPSTEAD, MD. 21074

State

Registrar

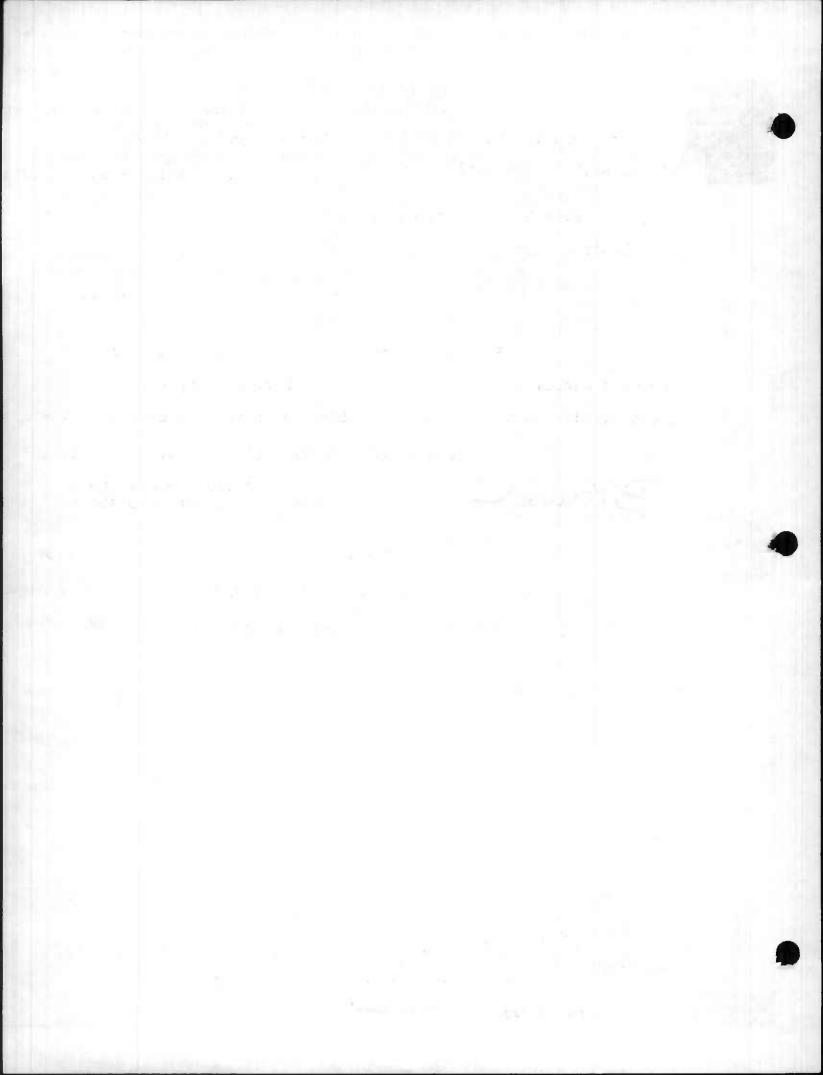


		1. Decedent's Nama (First, Middla, I	Last)					2. Date of De			3. Time of De
ysiciar		MAR	y. C.	The	ma	- 90		Januar	v 17	Yaar 1998	10:10
Medica :amine:		4a. Facility Name (If not institution, g		ber)	-		4b. City, Town, or L				
annie.	"	St. Mary Hospit	al				Leonardt	own	St.	Mary'	s
eral		5. Social Security Number 6. Sax 7. Age (In yrs. las			st birthday) If Under 1 Year If Under 24 Hrs.			8. Data of Bi	rth	9 Rirthplace (State or	
ctor		217-18-8912 1 M 2 XF 77 Yrs. Months Days Hours Min.					riours Min.	January 19,1920 Maryland			
	-	Usual Rasidance of Dacedant 10a. Stata 10b. County		10a City Tay	um aut aantia						
	2	The second secon	a w ** 1 a		wn or Locatio	OFT				1	0d. Insida City 1 ☐ Yes 2
	Director	Maryland St. Mary's Chaptico							10g. Citizan of What Country?		
ž ž	5	10e. Street and Number 10f. Zip Code								ntry?	
10	era	24051 Matting1					20621 Decedent of Hispanic Orlgin? (Specify Yas or		U.S.A. or No- 14. Race - Amarican Indian.		
	by Funeral	11. Marital Status 1 ☒ Naver Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force	as? No	If Yas	s, specify Cub	an, Mexican, Puerto	Rican, atc.)		ck, Whita,	atc.
1 3	8	15. Dacedant's				s Usual Occur	nation		16h Kind of B	Black 16b. Kind of Business/Industry	
10	Completed	(Specify only highest g	da complatad)		6a. Decedent's Usual Occupation (Giva kind of work dona during most of worki lifa. DO NOT usa ratired)			ring	TOO. KING OF B	bb. Kind of Business/Industry	
1	E	Elemantary/Secondery (0-12)	Collega (1-4or 5+)		Homemaker			Own	Own Home		
		17. Fathar's Nama (First, Middla, La.				18. Mothar's Nam	a (First, Middle				
	To Be	Harry Truma	n Thom	nas			Mary	Madeli	ne Cou	ntiss	3
F		19a. Informant's Name/Ralationship	(Type, Print)	19	9b. Mailing Ad	ddress (Street	and Number or Ru	ral Routa Numb	er, City or Town,	Steta, Zip	Coda)
		Gloria Ann Robin	son/Daugh	tor	Genera	1 Deli	very, Cal	laway,	MD 2062	.0	
		20a. Mathod of Disposition		20b. Place	of Disposition	n (Nama of ny or othar pla	ca)	Data	20c. Location	- City or To	wn, Stata
		1 N Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Othar (Space		ate		ct Ceme		1/24/19	98 Bush	wood.	, MD
		21. Signature of Funaral Sarvice Lic	ensaa		22. Nar	me and Addra	ass of Facility				
ical iner	liner	Immediata Causa (Final disaasa or condition resulting in death)	a. /A	Cufe Dua to (or as a	(Cr	Cfr	o res	(46) AL	ider	of	Interval Batwonsat end D
os the burial-transit	edical	disaasa or condition	a	Dua to (or as a Dua to (or as a Due to (or as a	consequence	ea' of):	6 V=5	,	ider) L	Interval Batwonsat end Di
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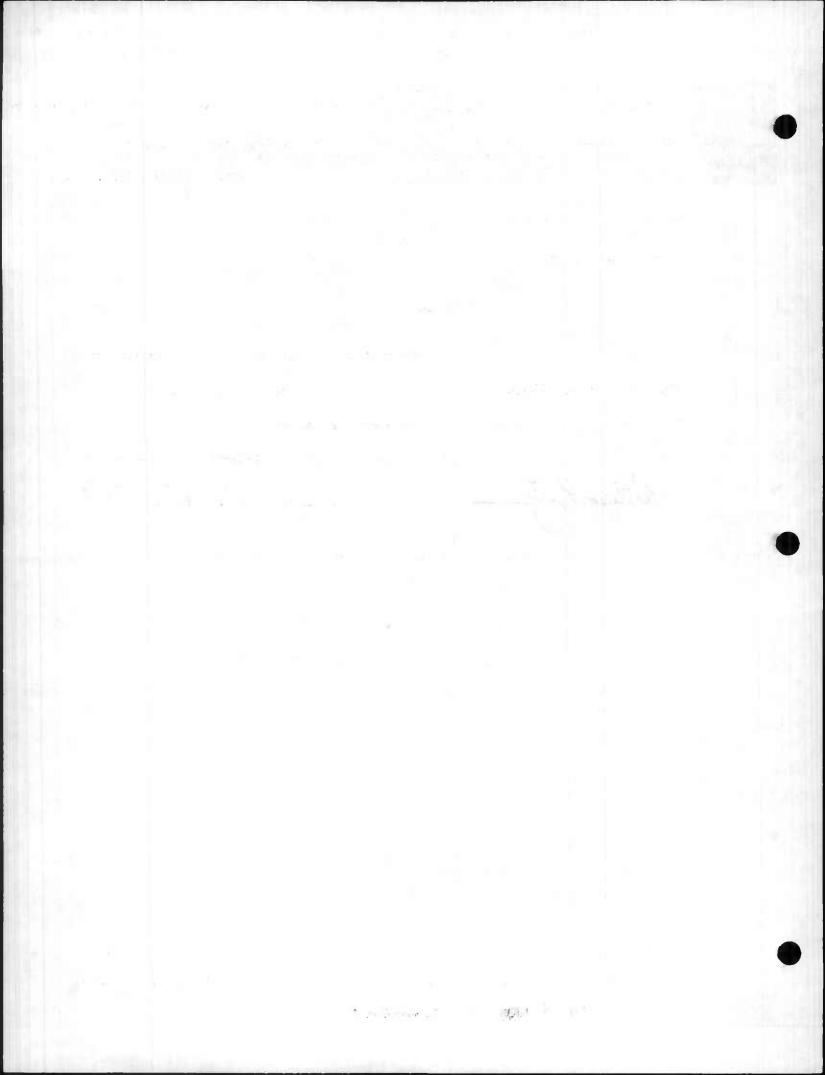
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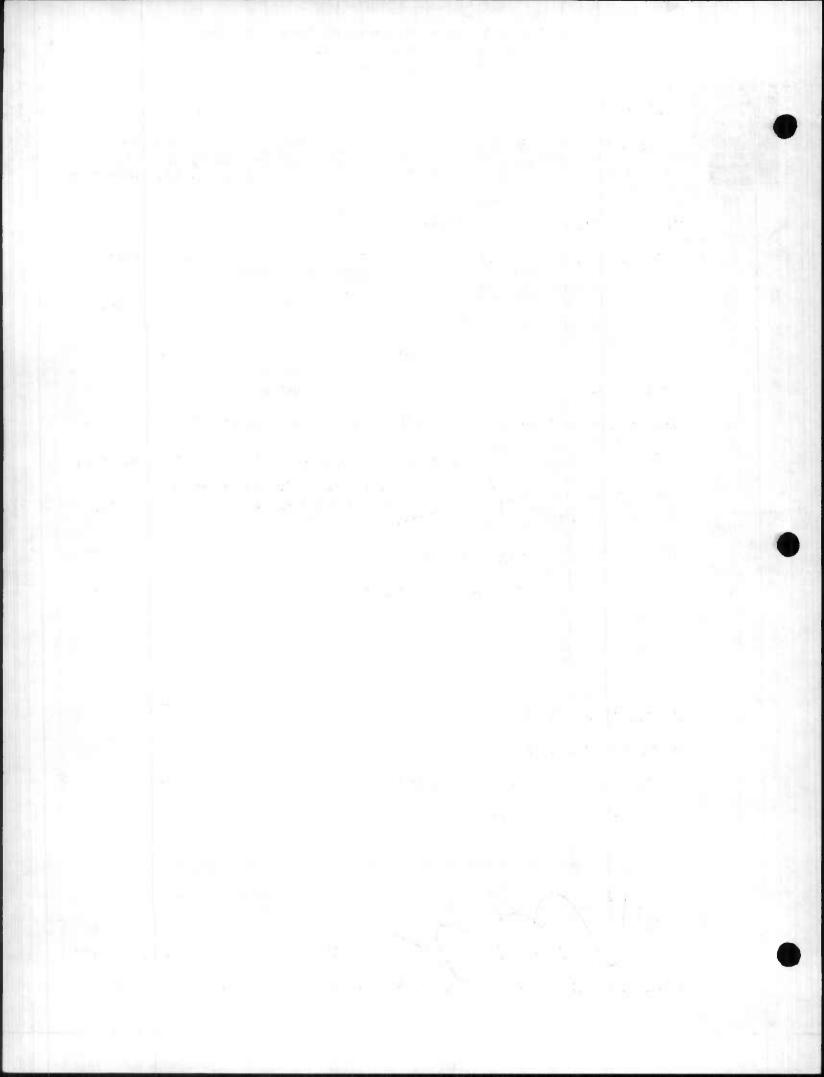
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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene ? 02882 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Death 3 Time of Careth **Physician** Vlakos, Jr. Michael E. 2025 /Medical 4e. Fecility Nama (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Deta of Birth (Months | Days | Hours | Min. | 8. Deta of Birth (Month, Day, Year) 6. Sex YOM 2□ F 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Yrs. 577-44-3169 65 Director Mar. 5, 1932 Washington, DC Usual Rasidance of Dacedent 10a. Stata 10b. County r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at 10c. City, Town or Location 10d. insida City Limits 1 XYas 2 No Director Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 126 Hearne Road Apt. T-1 21401 USA death Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 [∄/¥ss 2 □ No If Yas, Giva Yaar or Datas: 1955–58 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Ricen, atc.) Raca - Amaricen Indian, Black, Whita, atc. filed within 72 hours after Hygiene. Ither than "natural", or ite 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yas XXNo Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Spacify only highest greda complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) permit. Peges 1 and 2 should be filed wit Depertment of Heelth end Mental Hygiens Important: If tiem 27 is marked other tha any injury or other traumetic event, that once. Owner- Self Employed yrs. Steel Construction Co. 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Surname) Be Michael E. Vlahos, Sr. Pauline Kirschbaum 19a. Informant's Name/Ralationship (Type, Pnnt) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Virginia L. Joy/ Daughter Annapolis, Maryland 21403 317 Canterfield Rd. 20a. Method of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 D Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Hillcrest Cemetery 1-20-98 | Annapolis, Maryland 22. Nama and Address of Fecility
George P. Kalas Funeral Home 21. Signature of Funeral Service Licensea 2973 Solomons Island Rd. Edgewater, Md. 21037 23a. Part1. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween **Physiclan** /Medical Immadiata Cause (Final Anoxic Eucephologothe 1 wk disaasa or condition resulting in daath) Examiner Dua to (or as a consequance of): Examiner Pu Ecuoria 2 celes physicien and the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immadiate causa. Entar Undarfying Causa (Disaasa or Injury that initiated avants resulting In daath) Last Dua to (or es e consequance of): Box 68760 Physician/Medical Dua to (or as a consequance of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert 1. 23b. Did tobacco uaa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed I Records, Completed by 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an eutopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours effer deeth. Funeral Director: After this certifica stely filled in by the funeral director, I Be 25. Was casa rafarred to medicel examinar? 26. Placa of Death (Check only ona) Hospital: 12 Impatiant 2 ER/Outpatiant 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be determined 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Direct completely filled in by 29a. Certifler Medical 🗠 certifying Phyalcian: To tha best of my knowledge, death occurred at tha time, date and place, and dua to tha cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) un populyon MA 730768 1-15-58 30. Nama and addrass of parson who completed cause of daath (Itam 23a) (Type, Print) Tolen Julker, det, 7003 terdecal Pkry, burgules ted 21401

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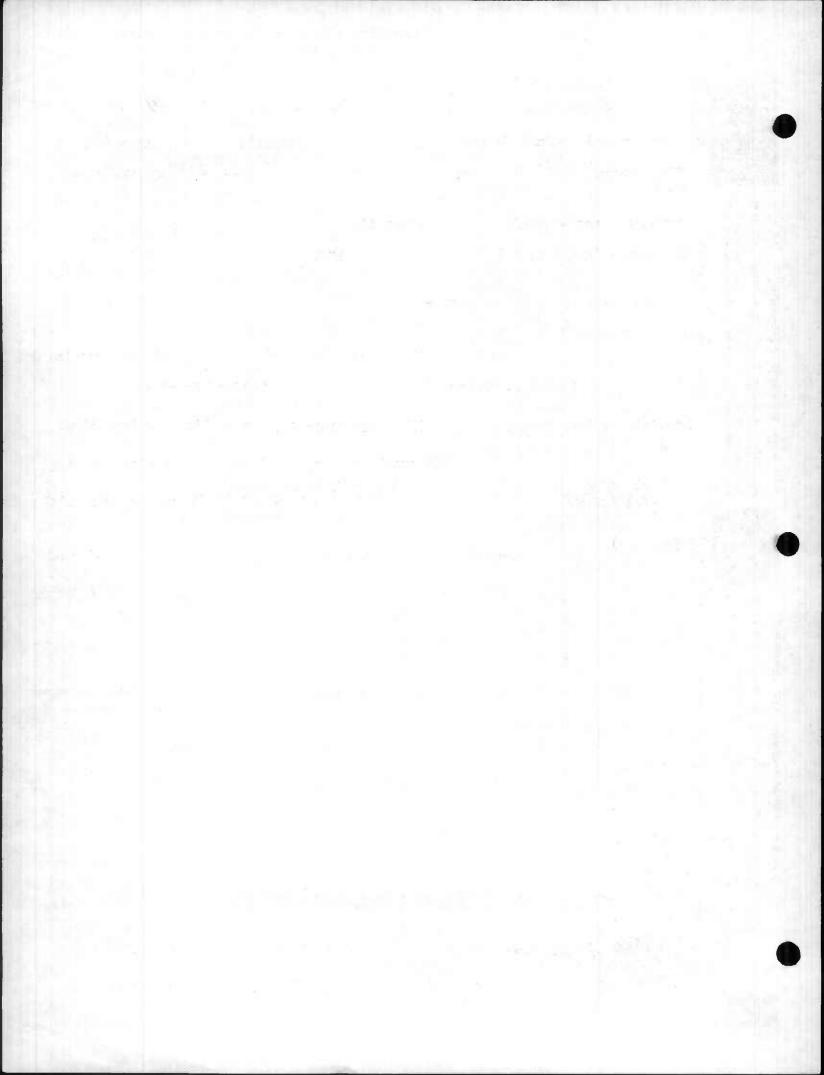
Registrar

31. Dete filed (Month, Day, Yaar)

JAN 21 1998

32. Registrar's Signetura

The Davidson-Randell



State of Maryland / Department of Health and Mental Hygiene

					Certifica	ale UI L	Jeani		Reg. No.	0 0	2000
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	to	Maryland Kent		Chi	urch Hill						1 ☐ Yes 2 🖾 N
	Sire.	10e. Street end Number				Zip Code			10g. Citizen of	Whet Countr	y?
	Funeral Director	P.O. Box 149				2162.	3		USA		
	nue	11. Marital Status	12. Wes Decedent 8 Armed Forces?	Ever in U,S.	13. Was De If Yes, s	cedent of His pecify Cuber	spenic Origin? (9 n, Mexican, Puer	Specify Yes or No to Rican, etc.)	0- 14. Rad Bla	ce - America ck, White, et	
	þ	1KMever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 N if Yes, Give Year or Dates:		1 ☐ Yes	20 No	Specify:		Specif		Black
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	ပိ	/ th 17. Fether's Name (First, Middle, Last	r)		1	abore:		eno /Firmt Ministe	-		p Compar
	Be		, sley Wrigh	t Sr				la Frisb	, Maiden Sumen	ne)	
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QUCE:		Karen A. Wright	rypo, r mny		P.O. Box					, Stete, Zip C	2006)
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	-	21. Signature of Theral Servica Lice		1.12	in the same of			1/17/98			/
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r	edical Examiner	disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events	b. Fover	dunt	s e consequence of the consequence of s e consequence of the consequen	isin.					
	dical	Ceuse (Diseese or injury that Initieted events resulting In deeth) Lest	c	Due to (or e	s e consequence o	of):					
			d								
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	by Physician/M									2 Duche	bly 4 🗆 Unkno
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		Dutypal ; HT Poriphoval Vasa	ular Diso	rse;	Urinery	lev; Retou	tion.	24e. Wes	Yes 2□ No en eutopsy ormed?	24b. Were eveil com	e eutopsy finding able prior to pletion of cause
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State of Maryland / Department of Health and Mental Hygiene 8

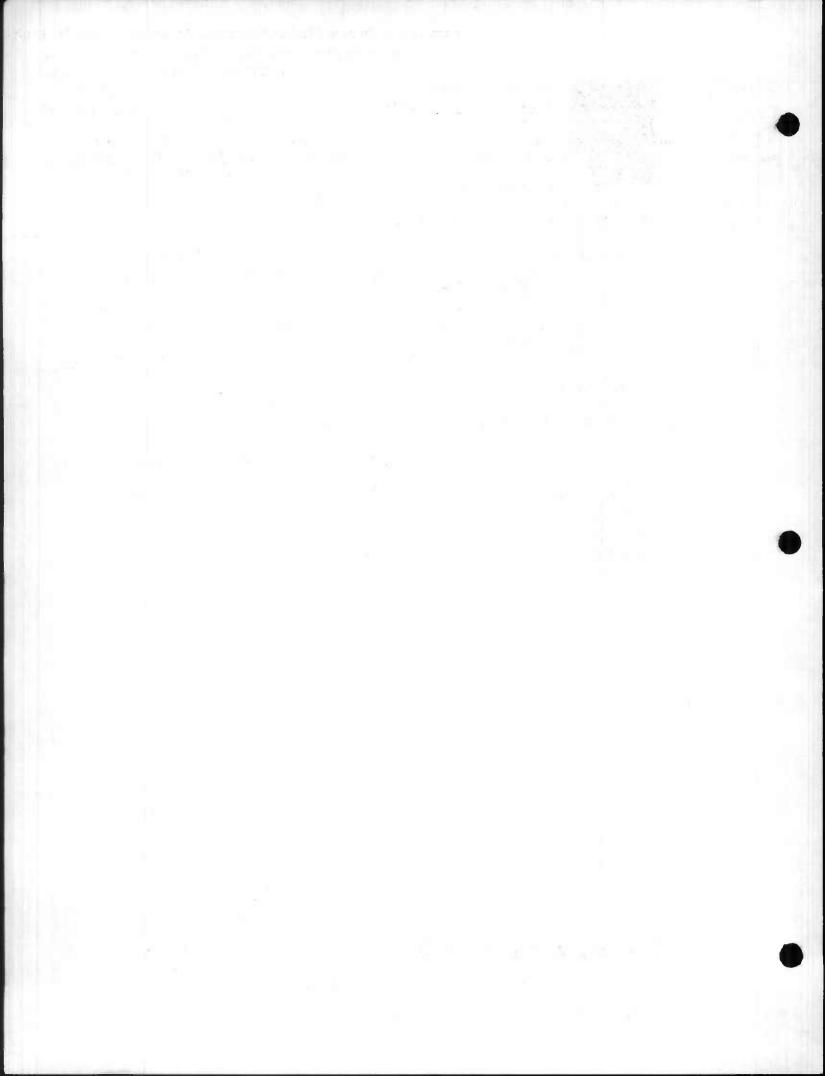
					Certifica	ate of	Death		Reg. No.	06	004
Dhualat		1. Decedent's Name (First, Middle,	Last)					2. Date of Dec	eth		Time of Death
Physicia /Medic	_	WILLIAM ELLSWO	ORTH WRIGH	T JR.				JANUARY	16 '	Yaar 1998 1	603
Examin		4a. Fecility Name (If not institution, g	give street end number)			-	b. City, Town, or	Location of Death		y of Death	005
		KENT AND QUEEN		PITAL	1		CHESTERT	OWN	KENT		
Funeral		Social Security Number	5. Sex 7. Ag 1 XM 2 ☐ F	e (In yrs. lest bii	Month	er 1 Year s Days	If Undar 24 Hrs Hours Min				(State or Fora
Director		220-02-5743 Usual Residence of Decedent	TODAY ZUF	17	Yrs.			January	7,1981	maryla	nd
natural, or items 23a or 28a-f show	-	10a. Stete 10b. County		10c. City, Tow	n or Location					1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	nside City Limi
28a-f shor	cto	Maryland Kent		Cheste	rtown					1	X Yes 2□1
0 8	Director	10e. Street end Number			10f. 2	ip Code			10g. Citizen of	Whet Country?	
238		114 1st Stree	et			620			USA		
or items 23s	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Wes Dec	edent of H	ispanic Orlgin? (Specify Yes or No- rto Rican, etc.)	14. Ra	ce - American Ir	dien,
	by	1 Never Marriad 2 Merriad 3 Widowed 4 Divorced	1 Yes 2 1 If Yes, Give Year or Dates:	No		37	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specia	fy:	
"natural", egical Exa	Pe	15. Decedent's	Education	16e.	Decedent's Us	uel Occup	etion		16b. Kind of P	Black Business/Industr	v
-	Completed	(Specify only highest of Elementary/Secondery (0-12)			(Give kind of viife. DO NOT	vork done d use retired	during most of wo	orking	TOD. THIS OF E	, a 311 10 33 11 10 0 31 1	,
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othe ent,	Bec	17. Father's Name (First, Middle, La.	st)		Deaden		18. Mothar's Na	me (First, Middle,			uncy 5
important: If item 27 is marked other than any injury or other traumatic event, If a M once.	To B	William E. Wrig	oht Sr				Debor	ah a. Rya	nc		
E L		19a. Informent's Neme/Reletionship		19b	. Mailing Addre	ss (Street		ural Route Numbe		Stete Zin Cod	(e)
27 ls		Deborah A. Cheen	ra (matham)								,
othe		20e. Method of Disposition	is (mother)	20b. Plece of	Disposition (N	eme of		ille,Mary		- City or Town,	Stete
7 0		1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec			ry, cremetory of		1	1 101 100			
infur	-	21. Signeture of Funeral Service Lip	•	Rich			metery ;	1/24/98	Chester	town, Ma	ryland
Department of Health and Mental Hygiene, Important: if item 27 is marked other than any injury or other traumatic event, trail once.		21. Olgitotate of 1 different strong	0.1900				,	eral Home	9		
		1000			P.O.	Box	1687.Ea	ston, Mar	rvland	21601	
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ledical aminer		Immediate Ceuse (Finel disease or condition	Mult	ale	ches	1	+ ald	minal	hise	110	
		resulting in death)	. 424 - 52 - 54	bue to (or es e	consequence o):	0,00		- pu	VCC-	
*	Examiner										
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tac								1 U Y	es 2 No	3 Probabiy	4 Unkno
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Bea No. 98

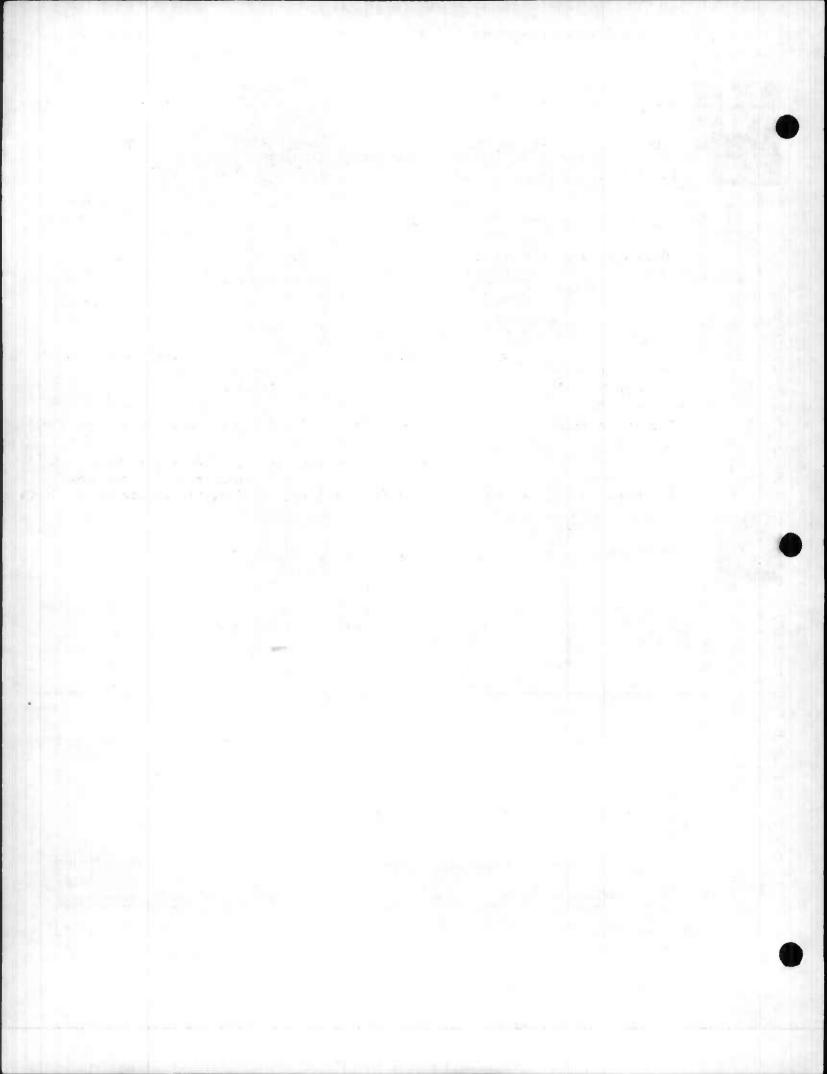
					C	ertificate	e of	Death			Reg. No.	0	12885
Dhysisis		1. Decedent's Neme (First, Middle	e, Last)							2. Dete of Dec	eth Day	Year	3. Time of Deat
Physicia /Medica			Seymour		Witco	off				January	19,	1998	4:45 AM
Examine	er	4e. Facility Neme (If not Institution		per)						cation of Deeth	7.7.7.7	inty of Deeth	
			nut Drive			If Under	- 1	Rockv				ntgome	
Funeral Director		5. Social Security Number 579-42-5957 Usual Residence of Decedent	6. Sex 7.	Age (In yrs. le	Yrs.	Months	Days	Hours	Min.	B. Dete of Birt (Month, De June 6,	7, Year) 1933		hplece (Stete or Fore untry) aryland
tal Hygiene. d other than "returel", or items 23s or 28s-f show event, the Medical Exercities must be notified at		10e. State 10b. County		10c. City,	Town or	Location		11					10d. Insida City Lim
28a-f show	to	Maryland Monto	gomery	Roc	kvil	le							1 ☐ Yes 2火☐
23a or 28a	Dire	10e. Street and Number	nut Drive			10f. Zlp	Code 2085	3	-		10g. Chizen United		•
items 2	Funeral	11. Marital Status	12. Wes Deced	ant Evar in U,S	6. 10	3. Was Deced	ent of H	lispenic Orl	gln? (Spe	cify Yes or No	14. F	Race - Amer	ricen Indien,
ef, or items 23s or 28s-f shore. Examiner must be notified at	þ	1 ☐ Navar Marriad 2 ☐ Marriad 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giva	□ No 195		If Yes, spec			i, Puarto	Ricen, etc.)		Bleck, White Boify: Wh	a, atc. nite
	ted	15. Deceden	t's Educetion		16a. Dec	cedent's Usua	I Occup	ation	a of coords		16b. Kind o	f Business/I	
ir result and Mental rivglene. Item 27 is marked other than "naturel", or other traumatic event, tra Meulical Euen	Completed	(Specify only higher Elamentery/Secondery (0-12)	Collega (1-4	or 5+)	life	ve kind of wor DO NOT us ancial	e retire	d)		8	Comput	er Se	ervices
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Aenta rked tic e	ToE	Joseph Wito	coff					Zin	a C	eppos			
S THE		19a. Informent's Neme/Rejetions	hip (Type, Print)	2.	19b. Me	iling Address	(Street	end Numb	er or Rura	al Route Numbe	or, City or To	wn, Steta, Z	(ip Code)
em 27 i		Rosemary Agnell	o Witcoff	(wife)		Same a	as 1	0					
nent of He int: If item iry or oth		20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 4 ☑ Donetion 5 ☐ Other (S)		ata ce	metery, c.	position (Nam rematory or of	ther ple	ce)	11 -	Data _ 1 9 _ 9 8	20c. Location		Town, Stata aryland
Department of Health Important: If item 27 eny injury or other to once.		21. Signature of Funerel Sarvice				22. Name end Rapp F	d Addre	ral S	ervi	ces, P.	Α.		
	-	Cillen	W. May	4						ilver S		MD	20910
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State of Maryland / Department of Health and Mental Hygiene

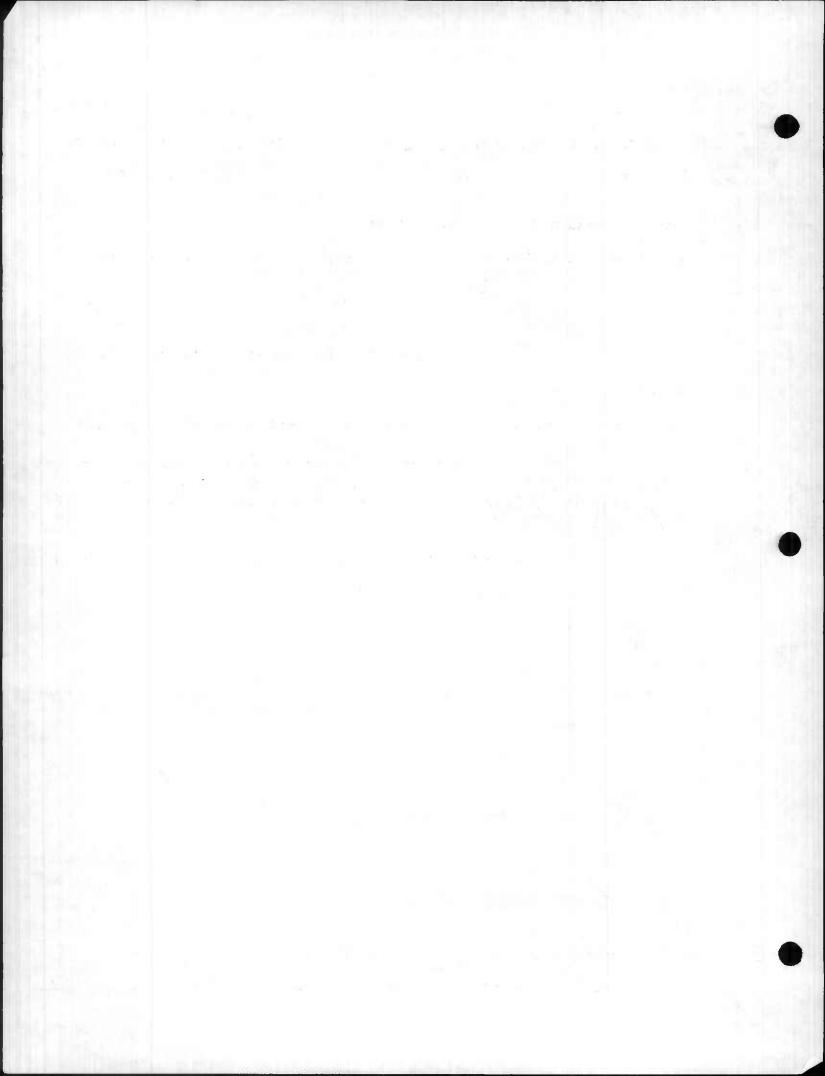
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sumatic avent, 1 To Be Cc		19e. Informent's Neme/Reletions	hlp (Type, Print)	(0)	19b. Malling	Address (Street	end Number or Rur	al Route Numbe	er, City or Town, S	itate, Zip Code)
	7	Vickey Brooks,	Daughter		6 N. S	ummit D	r., #101	Gaither	sburg, M	D 20877
		0a. Method of Disposition			ece of Dispositi	ion (Name of tory or other ple	ce)	Date	20c. Location - C	ity or Town, Stete
ry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		В		tan Crem	ة ل	an. 21,	levandri	la, Virginia
Important: any Injury once.	2	21. Signature of Fungual Service	Licensyle	Tice		lame end Addre	es of English		ineral Ho	
any lr		14.	4:		10	Fact Do	er Park D			
	1	23a. Part . Enter the efficiese, or shook, or heart failure. List	II complications that cause	ed the death.						Approximete
ician	ľ	shock, or heart falluly. List	only one ceuse on each	line.						Intervel Between Onset end Deeth
dicai	1	mmediate Ceuse (Final	Too	Lani	· R	0,,,0				406
niner	1	disease or condition resulting in death)	eX	Due to for	es e conseque	poce of):		-		T8 10
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ng physician end es the buriel-trans	ti	Ceuse (Disease or Injury	c	Due to (or	es e conseque					1
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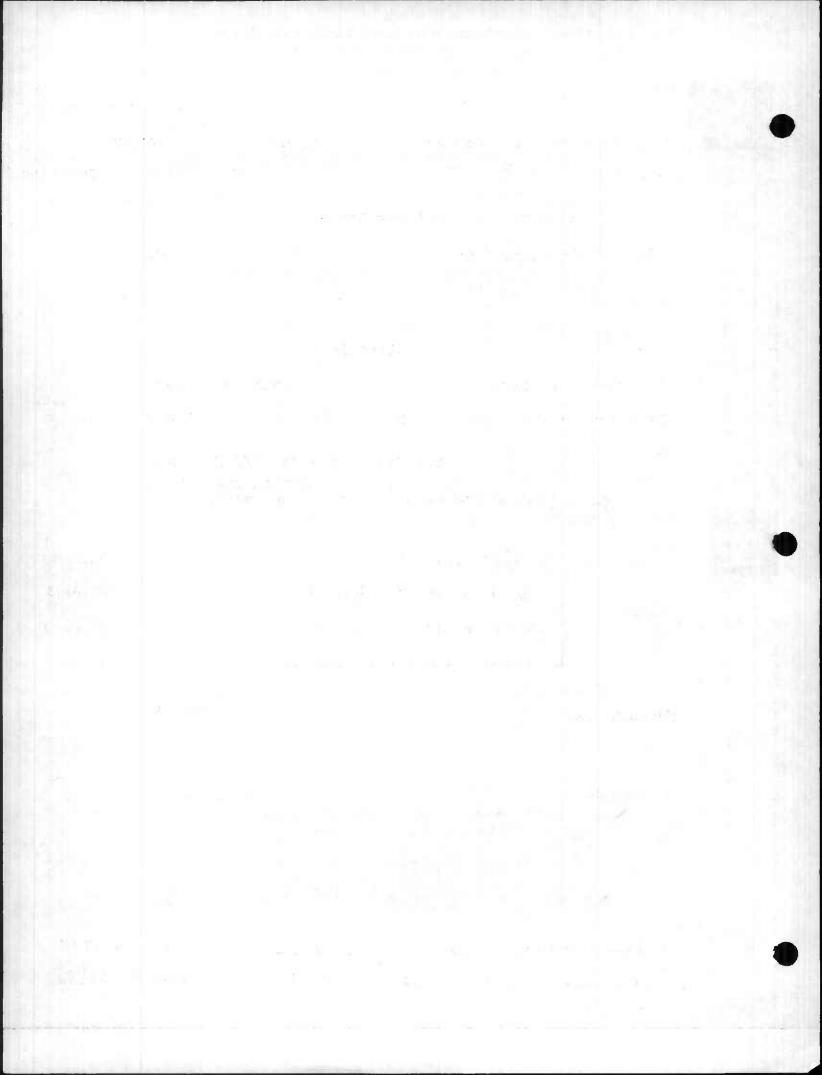


State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month **Physician** WORKMAN VIOLA L. JAN 15, 1998 6:45 P. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital MONTGOMERY Olney 8. Data of Birth (Month, Day, Year) May 1,1922 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Undar 1 Yaar | If Undar 24 Hrs. 9. Birthplaca (Stata or Foraign Country) S. Carolina **Funeral** 1 M 2 X Months Days Hours 75 S. Director 380-24-1903 Usual Rasidance of Decedant the Marylend 10a Stata If itam 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Experience must be notified at 10b. County 10c. City, Town or Location 10d. Insida City Limits Director MD Silver Spring 1 Yas 2 No Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? deeth with 13811 Blair Stone Lane 20906 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: Black P 3 X Widowed 4 ☐ Divorcad Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacadant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mentel Hyglans. Important: If fram 27 Ia marked other than any injury or other traumatic event Elamentary/Secondary (0-12) College (1-4or 5+) Dietician Hospital 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Constance Williams Kathleen Greer 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 20906 Llewellyn Mosely (Son) 13811 Blair Stone Ln, Silver Spring, 20a, Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Geo. Washington Cem 1/20/98 Adelphi, MD 21. Signature of Funeral Service Licenses SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or have failure. List only one ceuse on each line. Approximata Intarval Batwaan Onsat and Death **Physician** /Medical Immadiata Cause (Final disaasa or condition rasulting in daath) Osteomyelitis 4 months Examiner Examiner Type Diahetes Mellitus attending physician end for use as the burial-trensit certificete be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaase or Injury that Initiated evants rasulting In daath) Last Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical Peripheral Vascular Disease Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Malnutrition þ page 2 should be Completed 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? peed this cartificata has 1 Yas 2 No 1 ☐ Yas 2 No Division of Vital 25. Was casa raferred to medical examinar? Be 28. Place of Death (Chack only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Medicai Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the complataly filled in by the funera 28b. Tima of 28d. Describe how Injury occurred 28c. Injury et Work? After t 1 Naturel 2 Accidant 5 Pending invastigation 1 ☐ Yas 2 ☐ No 6 Could not be datarminad 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceusa(s) and mannar as stated.

2 Medical Examinar: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated. 29a. Cartifiar 29b. Signatura and titla of cartifiar 29c. Licanse number 29d. Data signed (Month, Day, Year) January 16, 1998 Dernett Morrison MJ D 47682 0 30. Neme end eddrass of person who completed cause of deeth (ttam 23a) (Type, Print) Olney, Maryland, 2901 Olney-Sandy Spring Road, Bennett Morrison 32. Registrar's Signatura 31. Deta filad (Month, Day, Yaer) State 20 1998 Wa Savidson-Randoll Registrar JAN



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** JAN MOSES A L WULFOW /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner 8. Dete of Birth (Month, Dey, Year) MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING 6. Sex 1 ☐ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Deys Hours Min. Yrs. 79 Director 532-22-1211 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MONTGOMERY SILVER SPRING 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 8 the Medical Examiner must be Norms 23a 10705 TENBROOK DRIVE 20901 USA Funeral 12. Wes Decedent Ever in U.S. Amed Forces?

1 Pres 2 No If Yes, Give Year or Dates: 1941-14. Race - American Indien. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 8 1 Yes 2 No Specify: Maryland 21215-0020 Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKBINDER US GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Mental Mental marked ISRAEL WULFOW MARIAM DORFMAN 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If flem 27 is n 5360 FALL RIVER ROW CT., COLUMBIA, MD 21044 VICKI GREISMAN / DAUGHTER 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete Buriel 2 Cremetion 3 Removel from Stete ò KING DAVID MEMORIAL GARD 1/18/98 4 ☐ Donetion 5 ☐ Other (Specify) FALLS CHURCH, VA 21. Signature of Funeral Serving Licensee 22. Name end Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 DANIEL SIMONS 23a. Pert1. Enter to die.) se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear death. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical **Examiner** Examiner physician and the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In deeth) Last 90 Physician/Medical Due to (or as e consequence of): Se JSe for 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed paga 2 After this certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical Be 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Empatient 2 ER/Outpetient 3 DOA funeral 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 27. Menner of Deeth 28c. Injury et Work? Certification: 5 Pending investigation 1 Neturel 1 Yes 2 No hours after death. uneral Director: Af 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 6 Hospital c 24 hours a Funeral D The Certifying Phyeicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner steted. 29e. Certifier Medical (Check only one) To the I within 2 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier Myron of Sentru No 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) LENKIN MYRON 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JAN 20 1998 uli Savidson Randelle

DHMH 16 Rev 6/95

Registrar

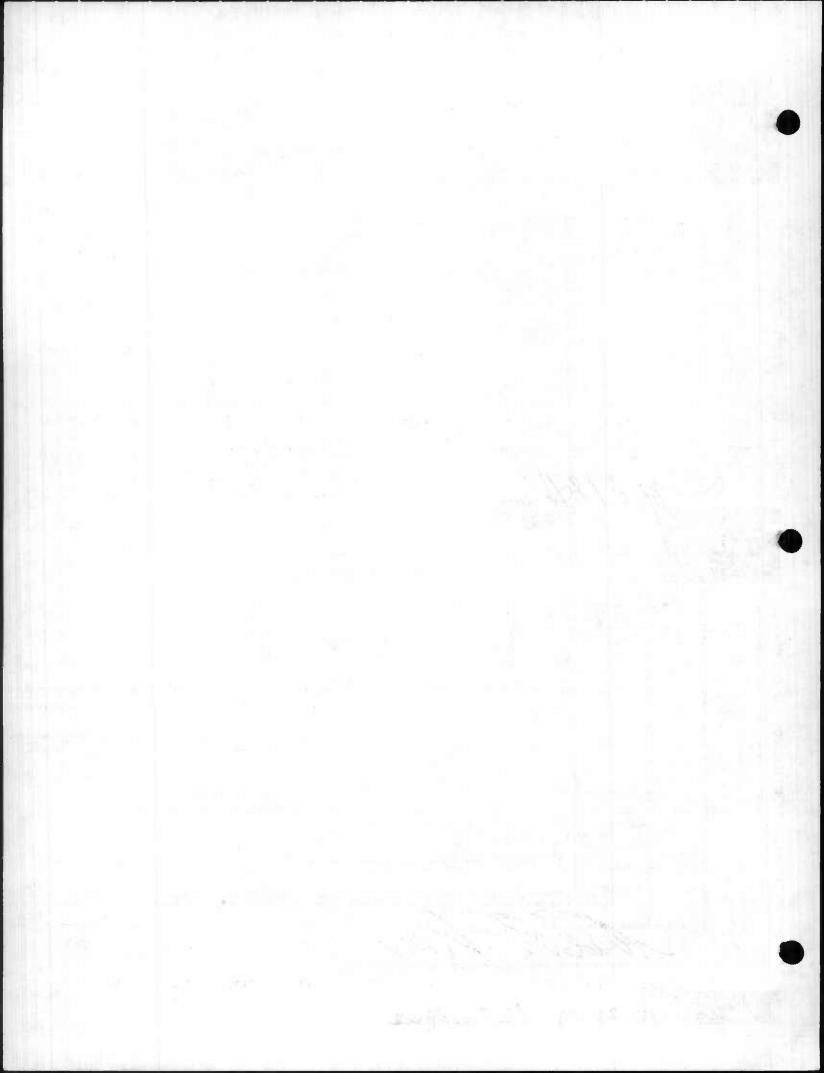
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Daath Month **Physician** Margaret L. Wynkoop 16, 1998 January 9:30 PM /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Potomac Valley Nursing Home Rockville Montgomery 5. Social Sacurity Number 6. Sax If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) 9. Birthplaca (Stata or Foraign Country)
September 25,1906 Washington, DC **Funeral** 1□M 2XF Months Days Hours 91 Yrs. 579-44-2027 Director Usual Rasidance of Dacedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location Show 10d. Insida City Limits r than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at 1 ☐ Yas 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 905 Kerwin Road 20901 United States Funeral 11 Marital Status 12. Was Decedant Evar In U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. filed within 72 hours eftar ☐ Yas 2 No 1 Navar Marriad 2 Married or or Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Completed by 3 ♥ Widowad 4 Divorcad White Yaar or Datas: 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiena. Elementery/Sacondery (0-12) College (1-4or 5+) Government Clerk United States Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maldan Sumema) Be Pages 1 end 2 should be filment of Health and Mental Hant! If Item 27 Is marked oth Mary Ellen O'Brien Herman Cameron Forney 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Nancy E. Dols/Daughter 4616 Eades Street, Rockville, Maryland 20b. Place of Disposition (Name of cematary, cramatory or other place) January 18, 1998 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata rtani. II 4 ☐ Donation 5 ☐ Othar (Specify) Bethesda, Maryland 21. Signature of Funeral Se Robert A. Pumphrey Funeral Home/Rockville, Inc. any l 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M00846 that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or or heart failure. List Approximate Interval Batween Onset and Death Physician Immadiata Causa (Final disaasa or condition rasulting in daath) /Medical Renal Failure 1 Week Examiner Dua to (or as a consequence of): Examiner Arteriosclerotic Vascular Disease The law requires that the deeth certificeta be executed Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Ceuse (Disaase or injury that initiated avants rasulting In daath) Last Dua to (or as a consequanca of): for usa as the buriel-trer Records, P.O. Box 68760, physician Physiclan/Medical Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings availabla prior to page 2 should Completed 24e. Was an autopsy parformad? peen complation of causa of deeth? cartificate has 2 No 1 ☐ Yas 1 TYas 2 No Division of Vital director, Attanding Physician: Be 25. Was case referred to medical axaminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Daath Data of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending invastigation death. 1 Tas 2 No spital or Attandi nours after death. neral Director: A 2 Accidant 3 Suicida 6 Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Steta) 4 Homlcide To the Hospital within 24 hours a To the Funeral D 10 Certifying Physician: To tha best of my knowledga, death occurred at the time, dete end placa, and dua to the causa(s) and menner es stated.

2 Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) 29a. Certifier Medical completely (Check only one) 29b. Signature and ti 29c. Licansa number 29d. Data signed (Month, Day, Year) D01120 January 17, 1998 D 30. Nama and address of person who completed cause of death (flem 23a) (Type, Print) M.D., 1299 Lamberton Drive, Silver Spring, Maryland Goozh, Walter E. 31. Data filed (Month, Day, Year) 32. Ragistrar's Signature State whice Davidson Registrar 20 JAN 1998

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** ASHINGTON 840 PM TELEN JANKARY /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death/ 4c. County of Deeth **Examiner** IST HOSPITAL

7. Age (In yrs. lest birthday)

Months Deys Hours Min.

Month, Deys Hours Min.

FEB. 28, 1944 MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL 5. Sociei Security Number 6. Sex Birthpiece (Stete or Foreign Country) **Funeral** 1□M 2♥F 220-40-5634 Director MARYLAND Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 □ No Director GAITHERSBURG MD. MONTGOMERY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20877 100 DUVALL LA. #301 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American indien, Black, White, etc. 11. Maritel Status 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 1 X Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify by 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONFERENCE CONTROL TECH. FED. GOV'T. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be FRANK WASHINGTON 0 HELEN 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CLOPPER RD. #A3, GAITHERSBURG, MD. 20878 TAWANNA KING/ DAUGHTER 901 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriai 2 【Cremetlon 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) CHAMBERS CREMATORY 1/22/98 RIVERDALE, MD. 21. Signature of Funerei Service Ligensee 22. Name end Address of Fecility 20910 CHAMBERS FUNERAL HOMES, P. A., SILVER SPRING, MD.

Approximete form of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. immediate Ceuse (Finel disease or condition resulting in deeth) cerebrorascular 11 days Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 TYes 2 No non small cell lung cancer þ 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☑ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred Medical Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturei 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted. (Check only one) 2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of certifier JANUARRY 20, 1998 20 400 C GEORGE A. SOTOS M.D. 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

CENTER

MEDICAL

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ROZINGUE, MD

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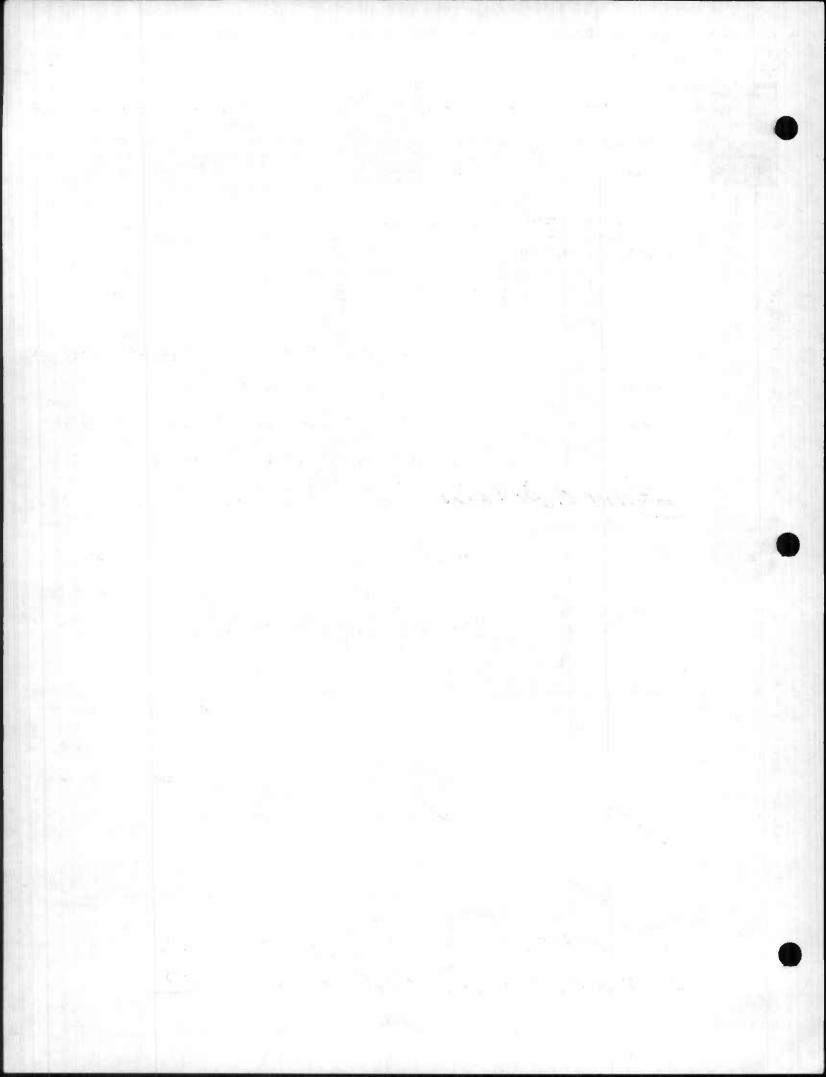
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State of Maryland / Department of Health and Mental Hygiene |

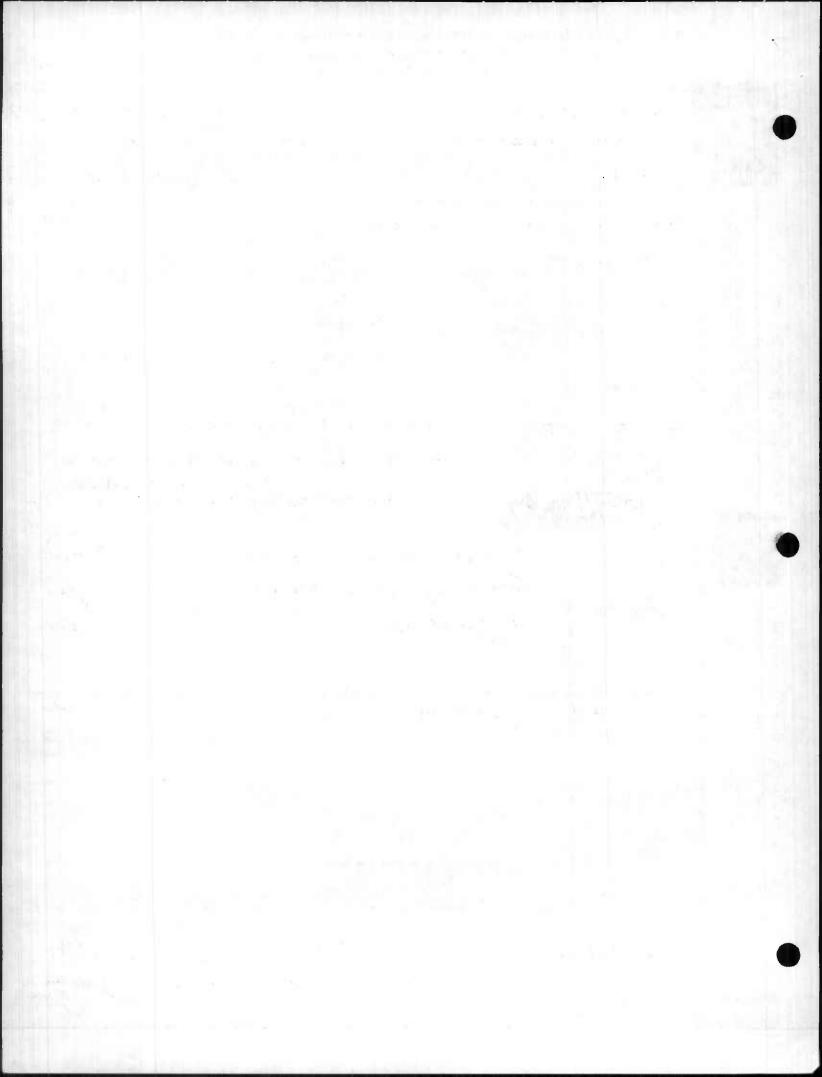
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Flynn Mack Wells 16,1998 January 6:55 A.M. /Medical 4b. City, Town, or Location of Daeth 4a. Fecility Nama (If not institution, giva street end number) 4c. County of Deeth Examiner Frederick Frederick Memorial Hospital Frederick If Under 24 Hrs. Hours Min. If Under 1 Year 8. Dete of Birth July 18, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 10XM 20 F 71 Arkansas 437-26-6285 Yrs Director Usuel Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Frederick Walkersville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8389 Inspiration Avenue 21793 United States permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23, any injury or other fraumatic avent, if the 2 section from the Funeral 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: Black þ 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Department of Elementery/Secondery (0-12) College (1-4or 5+) Relocation Officer Transportation 17. Fethar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John Overbee Sula Wells 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Michael F. Wells /son 8389 Inspiration Ave., Walkersville, MD 21793 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1/24/98 1 X Burial 2 ☐ Cremation 3 ☐ Removel from Stete Parklawn Memorial Cemetery Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012 Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate intarvai Betwe **Physician** /Medical Immedieta Ceuse (Final disease or condition resulting in deeth) PHYTIMICE Examiner Due to (or as e consequence of): Examiner avalomyopath physician and the burial-transit that the death certificete be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest CARDINASLIA DISEU Physician/Medicai Dua to (or as a consequence of) 98 980 for signed by the a 23b. Did tobecco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen this certificate has 1 Yes 2€ No 25. Was case referred to medical examiner?
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DHMH 16 Rev 6/95

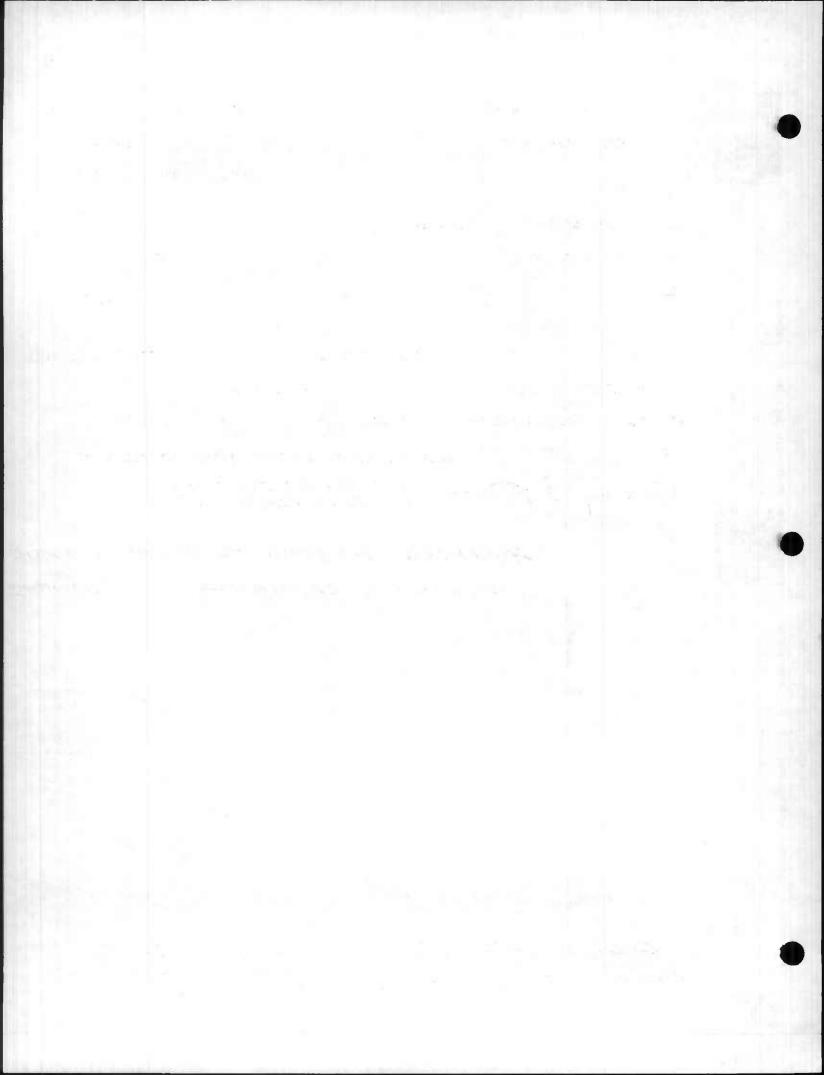


State of Maryland / Department of Health and Mental Hygiene 98 02893

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 02895 Item #5 per FH G756 2/10/98 EW State of AMEND# 20be1/20/98 cms AACO Health Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Deeth January 17 1998 **Physician** Edward Charles Watters, Jr. 12 Noon /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. Director 279-22-88698868 74 Michigan Usual Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiena. Hygiena. bther then 'netural', or Items 23a or 28a-f show ent, Ite Medical Examiner mant by notified at XX Yes 2 No Director Anne Arundel Annapolis 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 133 Spa View Avenue 21401 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: White g Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) 12 Consulting Engineer i. Pages 1 and 2 should be filed w tment of Haalth and Mental Hygler tant: If item 27 is marked other th jury or other traumatic event, the 4 plus Engineering Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maldan Surname) Be Edward Charles Watters, Sr. Charlotte Mermean 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Margaret Watters (Wife) 20a. Method of Disposition 133 Spa View Avenue Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stele Anna Polis, MD Marion, Onto Dete WBurial 2 Cremetion 3 Removel from State Mary's Cometery 1/21/98

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1/21/98 permit. Page Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funeral Servica Licansea 147 Duke of Gloucester St. Annapolis, MD21401 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only one ceuse on each line. Approximata Intervel Between **Physician** /Medical Immediate Cause (Fine) Meumonia disease or condition resulting in deeth) Examiner Due to (or es e consaguança of): Examiner The law requires that the death certificate be executed bunial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disease or Injury that initieted events resulting in daeth) Lest Due to (or es a consequença of): Box 68760. Physician/Medical the Due to (or es e consequence of): USB Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yes 2 No 3 Probably 4 Offknown م sate has been signed page 2 should be de Records, by 24b. Wara autopsy findings aveilable prior to completion of cause of daeth? Completed 24a. Was en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital or Attending Physician: director, 25. Wes casa referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28e. Dete of Injury (Month, Day Year) 27. Mannar of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division 1 Netural 5 Pending 1 ☐ Yas 2 ☐ No 24 hours after death. Investigation 2 Accident 6 ☐ Could not be datarminad 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) In by 4 Homicida Hospital 1 Cartifying Phyelcien: To the best of my knowledga, daath occurred at the time, date end plece, end dua to tha causa(s) and mannar es stetad.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date end plece, end due to the cause(s) end menner stated. 29a, Cartifiar Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signature end title of certifier 29c. Licanse number 29d. Dete signed (Month, Dey, Year) - ho 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 2023 Medical Policy MILLEN 31. Dete filed (Month, Day, Year)
JAN 2 0 1998 32. Registrer's Signature State Silia Davidson Registrar

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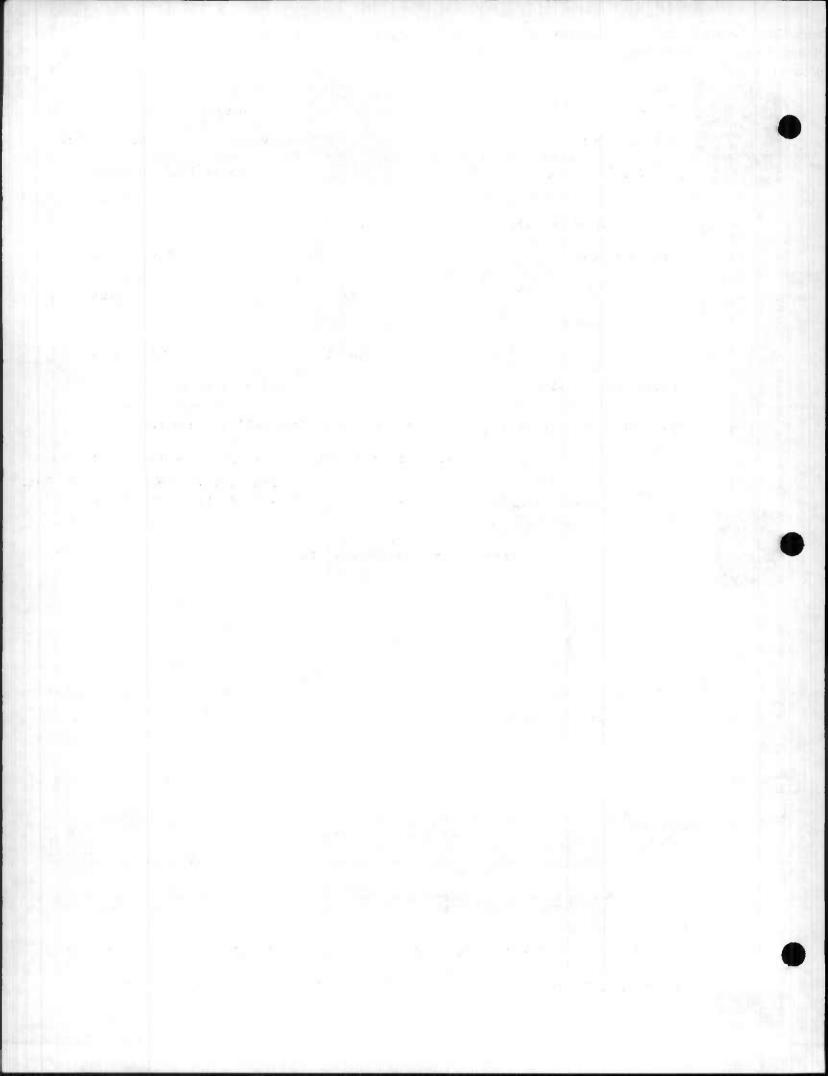
State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** Walter Burton Walsh 15 1998 9:35 p.m. January /Medicai 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 341 Hall Road Crownsville Anne Arundel Hunder 24 Hrs. 8. Data of Birth (Month, Pay, Year) Feb 14 1927 If Under 1 Year Months | Days 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** XXM 2□F Days Canada 213-22-6159 70 Yre Director Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or ftems 23s or 28s-f ehov traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director Anne Arundel Crownsville the 10e. Street and Number 10f. Zio Coda 10g. Citizan of What Country? 341 Hall Road 21032 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? A(∆Yes 2 □ No If Yas, Giva Yaar or Datas: "natural", or items 11. Marital Stetus 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indien, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health end Mental Hygiena. Important: if item 27 is marked other than "natural", or itea any injury or other traumatic event, the Medical Examinations. Black, White, atc 1 Navar Married XIX Married Baltimore, Maryland 21215-0020 Specify: White 1 Yas ZXNo þ 3 Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) President Oil Company 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) Be Frank Burton Walsh Marion McMurtry 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 341 Hall Road Crownsville, Maryland 21032 Jean Hall Walsh (Wife) 20b. Placa of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Deta 1 ☐ Buriel 2 XCramation 3 ☐ Ramoval from Stata Ft. Lincoln Crematory 01/17/98 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) 22. Name end Addrass of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Lice 147 Duke of Gloucester St. Annapolis, MD21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer feilure. List only one cause on each line. Approximate Interval Batween Onset end Death **Physician** /Medical immediate Ceuse (Final disaasa or condition rasulting in death) Chronic Obstructive Pulminary Disease 10 yrs. Examiner Dua to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disease or Injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of): 88 for use as 950 Division of Vital Records, P.O. the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Completed peen has 2 No certificete 1 ☐ Yas 1 ☐ Yas 2 ☐ No or Attending Physician: director, Be 25. Was casa referred to medical examinar? 26. Pleca of Death (Check only one) 1 Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🗡 Rasidanca 6 ☐ Othar (Specify) Certification: To this funerai 28a. Date of Injury (Month, Day Year) 27. Mennar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred After 5 Pending invastigation efter deeth.

Director: After d in by the fundament 1 TYas 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicida To the Hospital or A within 24 hours efter To the Funeral Direct completely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

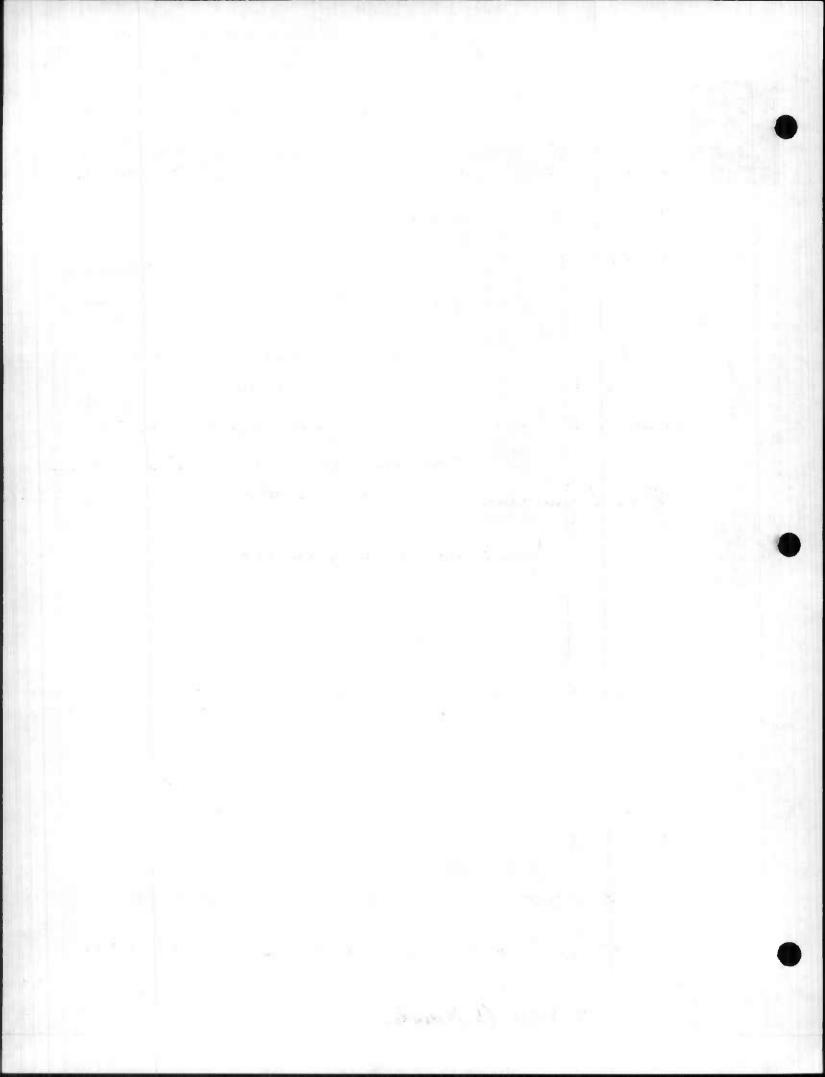
Madical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 015808 January 16, 1998 30. Name end eddress of parson who complated causa of daath (Itam 23e) (Type, Print) William E. Randall Jr., M.D. #33, 1205 York Rd., Lutherville, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signetura State relia Davidson JAN 2 0 1998 Registrar

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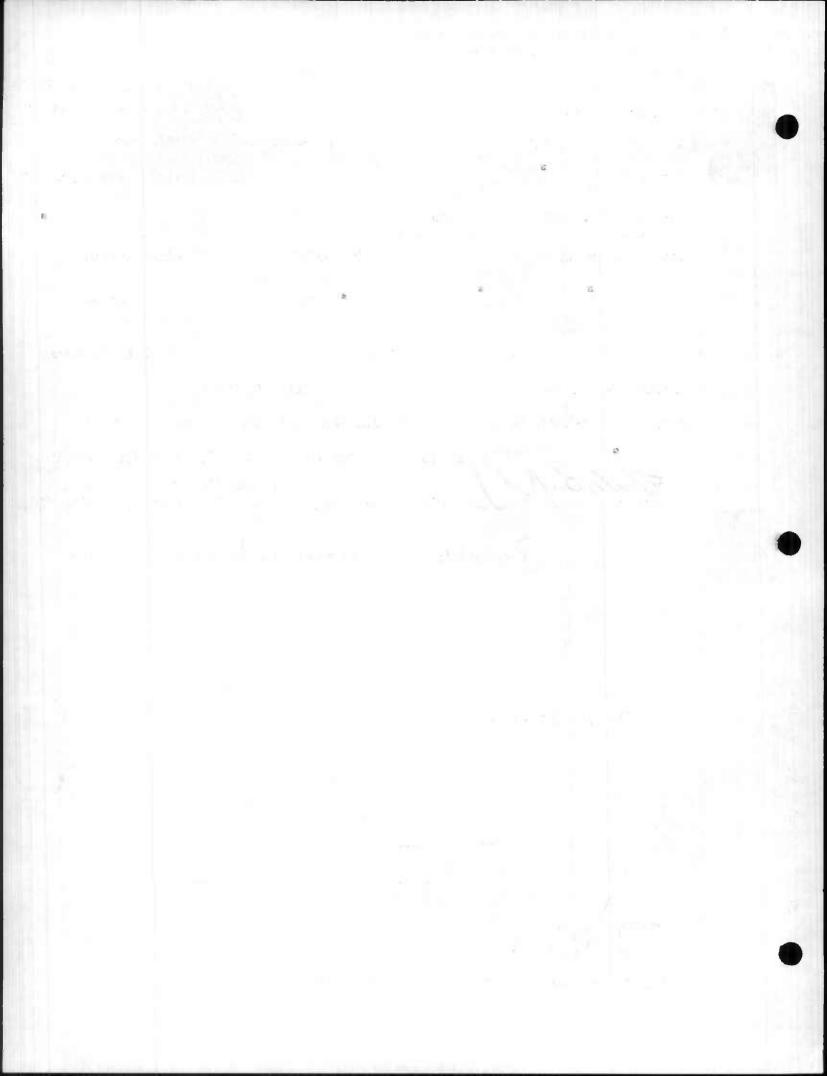
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State of Maryland / Department of Health and Mental Hygiene 98 02898

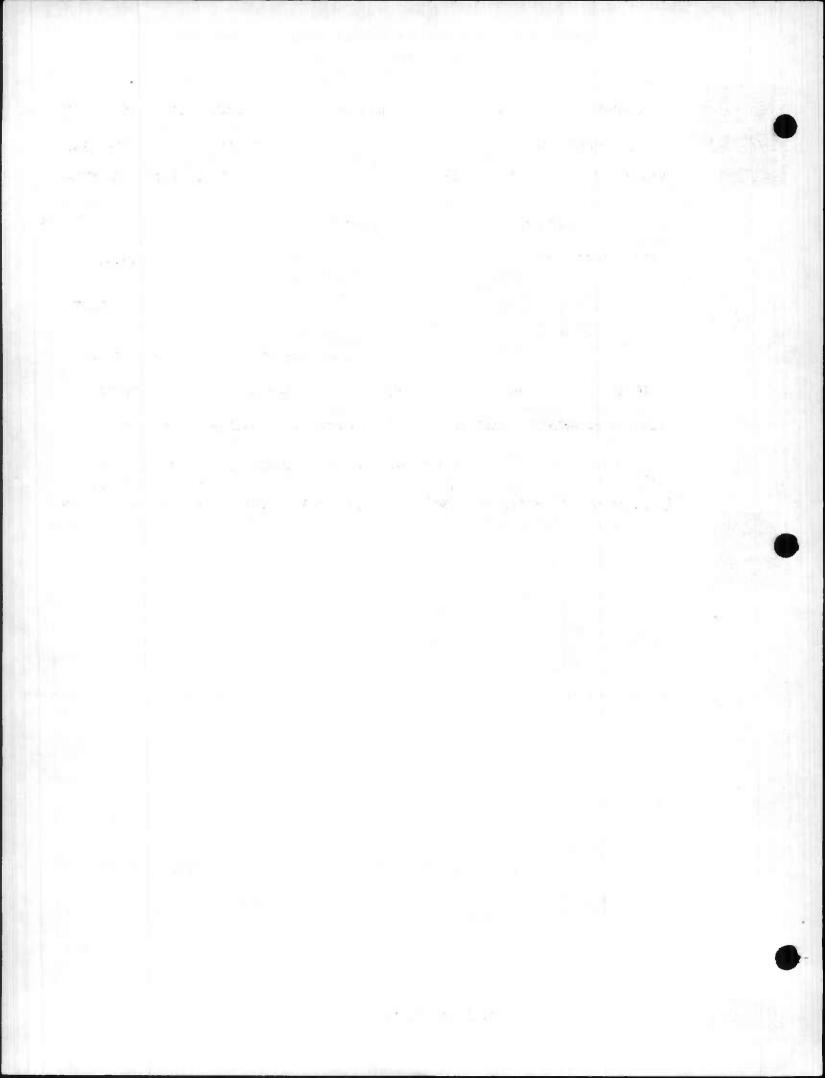
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permit. Pages 1 end 2 Department of Haalth Important: If Item 27 I any injury or other tra once.		Margaret B. Walker 20a. Method of Disposition 1 Burial 2 Cramation 3 DI 4 Donation 5 Other (Specify,	Ramoval from State	20b. Place of D	isposition (Na crematory or	me of othar ple	oa)		20c. Location -	City or To	
Physician / Medical Examiner be peroxected as the physician as the physic	ledical Examiner	23a. Part1. Entar tha disease, or comp shock, or haart failure. List only of immediate Cause (Final diseasa or condition resulting in death) Sequantially list conditions, if eny, leading to immediate causa. Enter Underlying Causa (Disease or injury that initiated evants rasulting in death) Last	b. Du		nsequance of	Ad					Intarval Between Onsat end Deeth
tha death cer by the attandir eched for use	Physician/M	Part II. Other significant conditions co		ot rasulting In th	na undarlylng	causa giv	en in Pert i.		bacco usa con		the ceuee of deet
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To the Hospital or Attending Physician: Thwithin 24 hours after death. To the Funeral Director: After this cartificate completely filled in by the funeral director, pag	Certification: To Be Co	25. Wes casa rafarrad to medical axeminar? 12 Yes 2 No 27. Wanner of Death 1 KNatural 5 Panding Investigation 3 Suicida 6 Could not be detarmined	Hospital: 1 Inpatient 28a. Data of Injury (Month, Day Yill) 28a. Place of Injury building, atc. (%)	- At homa, farm	ne of lry M	28c. Injur Wor 1 🔲	ar: 4□ Nursing I	ath (Chack only on Homa 5 Rasida 28d. Dascribe ho	once 8 Other	ar <i>(Specif</i>) ed	
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		30. Nama and addrass of person who of William D. Boyd 31. Data filed (Month, Dey, Yaar)	· ·	Leon	ardtow	n, Ma	aryland	20650			

NAME: ROBERT ALVEA WALKER



State of Maryland / Department of Health and Mental Hygiene

/sician		1. Decedent's Neme (First, Middle	Last)							2. Dete of Deal	th Dev	Yeer 1998 8: Dunty of Deeth WICOMIC 9. Birthplace (Signature) 10d. Insident of Whet Country? U.S.A. Reca - American India Black, White, etc. Decity: WHIT of Business/Industry TURPIN TOWN, Stete, Zip Code) 21804 tion - City or Town, Stete 3RON, MD MAIN ST. (RY, MD 218) Approximately Approxim	3. Time of Deeth
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eral			6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs		Months		If Under 2	24 Hrs. Min.	8. Dete of Birth (Month, Day)	Year)	9. Birthp	place (State or Fore
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1998 0710 Mildred Taylor Williams benuary 6 4a. Fecility Name (If not institution, give street and number) 4b. Clty, Town, or Location of Death 4c. County of Death WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours Months 1 M 2 KF Yrs. 67 231-32-9092 Jul 12,1930 VA 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No VA Accomack **Bloxom** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14575 Bethel Church Rd. 23308 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. I ☐ Yes 2X No If Yes, Give Yeer or Dates: 1 Never Married 2 N Married 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Melvin C. Taylor Helen Godwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Roy Williams, husband 14575 Bethel Church Rd. Bloxom, VA 23308 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Groton's Cemetery 1-9-98 Hallwood, VA 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Thornton Funeral Home, Par Thornton Funeral Home, Par Thornton Funeral Home, Par Shock, or heart failure. List only one cause on each line. Thornton Funeral Home, Parksley Approximete Immediate Cause (Final disease or condition resulting in death) (el Dio vasulos Cardinania'r There schulic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 V No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | Ne. 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records,

after death 8

Physician

/Medicai

Examiner

Funeral

Director

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Hygiene

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Physician

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Pages

Baltimore, Maryland 21215-0020

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Completed the Medical

24 hours a e Funeral C To the Within 2 To the

> State Registrar

29b. Signature and title of certifier

6 Could not be

2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHOMS

1 Certifying Physicisn: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end menner es steted.

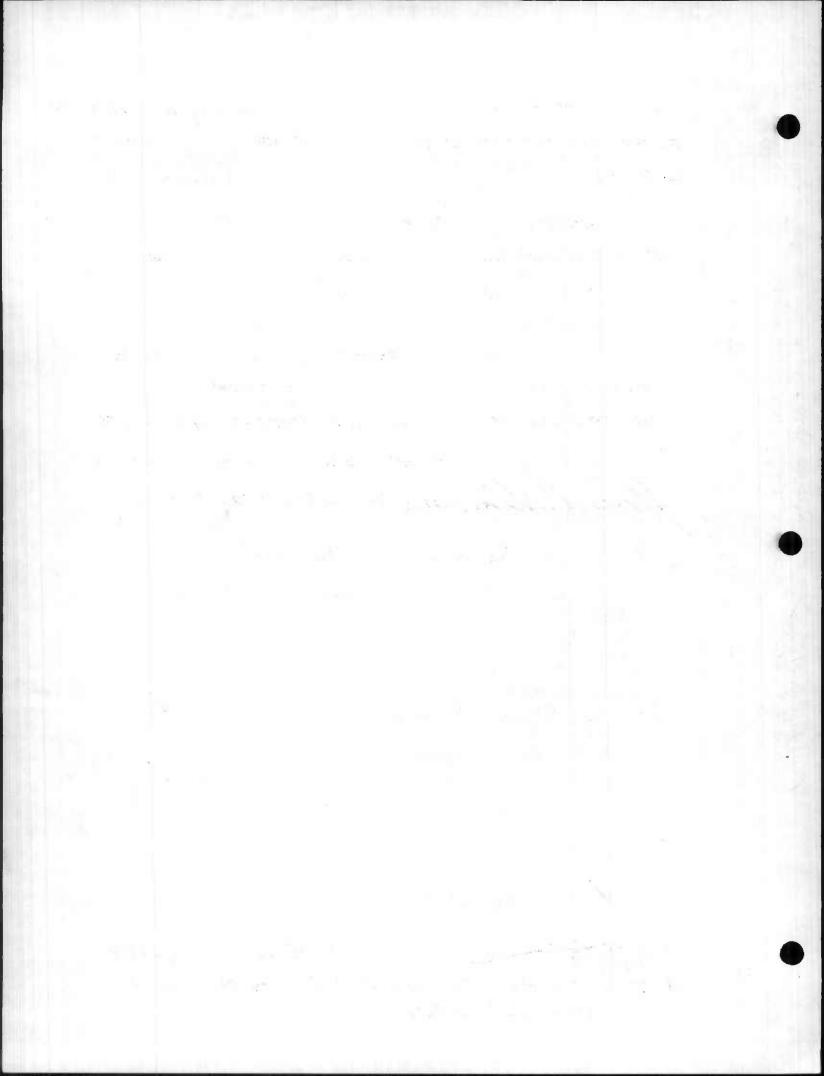
29d. Date signed (Month, Dey, Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

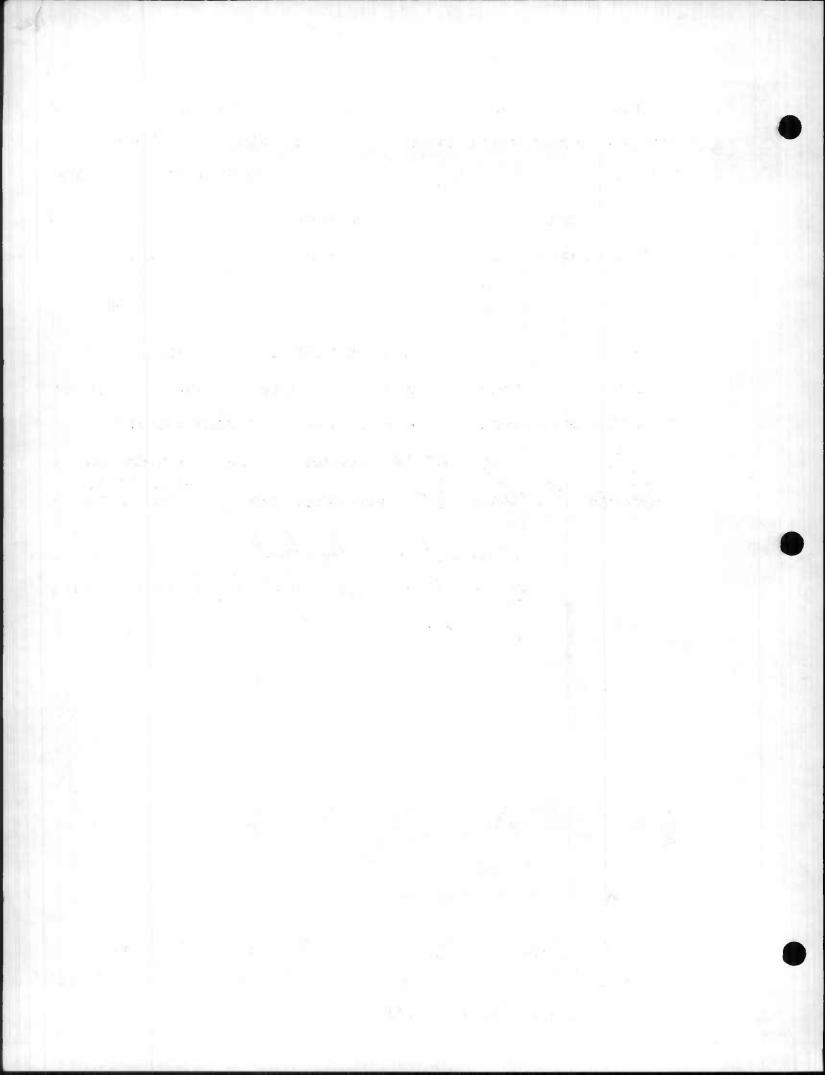
1D 403 QUINCY St. SALISBURY Md. 21804
132. Registra's Signature
Lindawdon-hardelle MD

31. Date filed (Month, Day, Year) JAN 14 1998



State of Maryland / Department of Health and Mental Hygiene

	M	Decedent's Neme (First, Middle	n, Last)		061	rtificate of	Dodin	2. Date of Death	g. No.	3. Time of Deeth
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ineral		5. Social Security Number	6. Sex 7.		lest birthdey)	If Under 1 Year Months Deys	If Under 24 Hrs.			
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og-in-	Director		OMICO			1	SBURY			1 ☐ Yes 2X N
0 8 6	2	10e. Street end Number	In Device no			10f. Zip Code	0.04	10	g. Citizen of W	•
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0 1	by Funeral	1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Force	s? ①No		If Yes, specify Cub	Hispanic Origin? (S en, Mexican, Puert Specify:	Rican, etc.)		k, White, etc.
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eny ir		1 Sund	1 /m	>		OUND C FU	NEDAT HON			MAIN ST.
	+	23a Fert1. Enter the disease, or shock, or haart failure. List	complications that caus	ed the death			NERAL HON ng, such es cardiac			RY, MD 21804 Approximete
ician	1	shock, or haart failure. List					,			tritervel Batween Onset end Death
dical		Immediete Ceusa (Final disease or condition	My	ocar	dial	Inti	re Hon	/		4 hours
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dln		4 Homicide	building,	atc. (Specify	')			City or Town,	Stete)	
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Me		29b. Signature and title of certifier	Λ,			29c. Licens	se number	29	d. Date signed	(Month, Day, Year)
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0		30. Name and address of person v	no completed cause of	deeth (Itam	23a) (Type.	Print)		0 1	-11	7.0
0		31. Dete filed (Month, Day, Year)	Julian 1	f deeth (Itam	201	Print) Pine	Bluff	Pd So	ilisbur	y MD 21501



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

		-1	Decedent's Name (Fi	rst, Middle, Las	st)		Certii	ficate of	Death	2. Date of Deel	eg. No.	0 (3. Time of Death
	Physici /Medi		EDGAR	Н	UNLEY		VHITEHE			JANUAN	Day 7,1	Year 998	1224 pm
	Examir	ner	4a. Facility Name (If not PENINSUL.				ENTER		4b. City, Town, or Le SALISBU	040	4c. County WICOM		
	Funeral Director		5. Social Security Numb 214-32-21 Usual Residence of Dec	55 13	ex PM 2□F	7. Age (In yrs. 85	Vrs N	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,			elece (State or Foreign stry)
	inyland show			o. County		10c. City	y, Town or Locati	on				1	0d. Inside City Limits
	he Ma 28a-f s	Director	MD 10e. Street and Number	Wicom	ico	M	Mardela		ngs				1 ☐ Yes 2 No
	with 3a or							10f. Zip Code		1	0g. Citizen of 1		ntry?
	oms 2	Funeral	11005 Sha	rptow	12. Was Deci	edent Ever in U, orces?	S. 13. Wes	218 Decedent of H	3.3 / Hispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No-		USA ce - Americ ck, White.	
Maryland 21215-0020	be filed within 72 hours efter death with the Maryland ntal Hygiene. Ide offer than "natural", or items 23a or 28e-f show event, the Medical Examiner must be notified at	by	1 Never Married	Divorced	1 Tes If Yes, Giv Year or D	2 1 No		Yes 2 No	Specify:	riioari, etc.)	Specify		hite
12-	in 72 h	Completed		Decedent's Ed	ucation de com <i>pleted)</i>		16a. Decedent	's Usual Occup	eation during most of work d)	ing	16b. Kind of B	usiness/Ind	dustry
212	d withing or than	ошо	Elementary/Secondar	y (0-12)	College (1	I-4or 5+)			and Farm		Farmi	na	
pu	be file tal Hys d othe	Be	17. Father's Name (First	, Middle, Lest)			11020		18. Mother's Name				
ryla	d Men marke	10	Alfred 19a. Informant's Name/		-	Whiteh			Florenc		nes		lrews
Z a	permit. Pages 1 and 2 should be filed within Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than any Injury or other treumatic event, the Managace.		Lloyd O.			er /er			end Number or Run				
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			23a Part 1 Enter the di	#4.	Chomp	aused the death	501	Snow Hi	11 Road, Sai	lisbury, M	D 21804		Assessments
	Physician		23a. Part1. Enter the dis shock, or heart fail	ure. List only	ne cause on e	ach line.	i. Do not enter ti	ie mode or dyn	ig, such as cardiac	or respiratory arre	351,		Approximate Interval Between Onset and Deeth
	/Medical Examiner		Immediate Cause (Final disease or condition			Athen	rosdo	Li	Cordiou	a cente	- de		soyrs.
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Box	oently organic	-		L	d								
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P.O.	i that the ned by the e detachs	y Phys	Insulin .	Depend	4		meli				8 2□ No	3 Prot	
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o no	ding Physilh. TAther this stuneral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 [☐ Pending Investigation	28a. Date (npatient 2 of Injury h, Day Year)	28b. Time of Injury	28c. Injun		me 5 Reside 28d. Describe ho			1) Gas Statten
Division	If or Atta after de Director d in by th	Certification:	3 ☐ Suicide 6 [4 ☐ Homicide	Could not be determined	286. Placa	of Injury - At ho ng, etc. (Specify	ome, farm, street,	factory, offica		28f. Location (St. City or Town	reet and Numb , Stete)	er or Rura	l Route Number,
	the Hospital thin 24 hours of the Funeral mpletaly lifed	edical C	29a. Certifier (Check only one)	Certifying Phy Medical Exami	iner: On the be	best of my know esis of examinat her stated.	wledge, death oci ion and/or Invest	curred et the tin igation, in my o	ne, date and plece, pinion, death occurr	end due to the ca	use(s) and me ate end placa,	enner as st	eted. the cause(s)
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	10		30. Name and eddress o	f person who co	ompleted caus	e of death (Item	23a) (Type, Prin	t)	1			,	
	54	+0	31. Date filed (Month, De	y, Year)	ICEILLY 32/A	egistrar's Signal	106 M	11/ford	1 st. 5	alisho.	7 1	14.7	71804
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men in the world of the second Section Proposition Decision and and

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** January 18, Joseph Allen 1998 5:55 am /Medical 4e. Fecility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Prince Frederick Calvert H Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
Oct 5, 192 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sax Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2□ F Yrs. Director 72 220 16 8392 Maryland Usual Rasidance of Decedant the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits ral', or items 23a or 28a-f show Examiner must be notified at Maryland Anne Arundel Fairhaven 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? with 6353 20754 Genoa Road USA death Funeral 12. Wes Decedant Evar in U.S. Armed Forces? 1 M Yas 2 □ No If Yas, Giva Year or Datas: 1944–46 Wes Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Bleck, Whita, atc. 11. Marital Stetus Pages 1 and 2 should be filed within 72 hours aftar in nant of Haaith and Mental Hygiene. 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yas 2 No Specify: þ Specify: 3 ☐ Widowad 4 ☒ Divorced white Completed h and Mental Hygiene.
7 is marked other than "natur traumatic avent, my Medical 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) security Federal Govt. guard 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be Richard Benjamin Ward Mamie Hardesty 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Haaith a Gary R. Ward / son 2410 Wayne Gibson Rd., Huntingtown, 20639 or other t MD 20b. Placa of Disposition (Neme of camatery, cramatory or other pleca) 20e. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Buriel 2 In Cremetion 3 ☐ Ramoval from State important: If any injury o once. 1 - 18 - 98Departmant Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarel Sarvice Licensas 22. Nama and Address of Facility Rausch Funeral Home, Owings, MD William 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one hause on each line. Approximata Intarval Between Onset and Death **Physician** /Medicai Immediate Causa (Final disaasa or condition rasulting in daath) Examiner Examiner The law requires that the death certificate be executed physician and tha burial-transi Sequentially list conditions, if any, leading to Immadiata cause. Entar Undarlying Ceuse (Disaasa or injury that initiated evants rasulting in death) Last Due to (or es e consequança of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequança of): attending pl signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Renal u lum À should ! 24b. Wara autopsy findings evaileble prior to completion of causa of death? Completed 24e. Was an autopsy performed? CVA cartificata has b 1 Yas 2 No 1 Yas 2 No Attending Physician: director. 25. Was casa refarred to medical Be 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 ☐ Rasidanca 6 ☐ Other (Specify) 10 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Aftar this funaral Certification: 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of 1 Natural 5 Pending invastigation after death. Director: Aft 1 Yes 2 No 2 Accidant tha 6 Could not be 3 Suicida 28a. Placa of Injury - At home, ferm, streat, factory, offica building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida 6 24 hours Hospital 29a. Certifiar 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta end plece, end dua to the causa(s) and manner es stated. Medical complataly (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the I 29b. Signatura and tille of certiflar 29c. Licanse number 29d. Dete signed (Month, Dey, Year) MD 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) 12 1VA Prince Frederick, MD 20678 Shah, M.D. 32. Registrar's Signature

Talia Studen Randall 31. Data filed (Month, Day, Year) State JAN 20 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Courth 2. Dete of Deeth **Physician** 1998 8:21am January JOSEPH /Medical YINGER 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Memorial Hospital at Easton Easton Talbot 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Hours Director 273-18-9243 Dec.2,1919 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD. Talbot Easton Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò Berns 23s 28072 Cove Court 21601 USA Funeral 12. Was Decedent Ever In U,S.
Armed Forces?

12 Ves 2 □ No
If Yes, Give
Year or Detes: 1944-46 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. "natural", or iten edical Examiner 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Farmer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be i Department of Health and Mental i Important: If them 27 is marked or any injury or other traumatic eve Jacob Yinger Bertha Bard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 28072 COVE Court, Easton, MD 21601

20b. Place of Disposition (Name of cemetery, cremetory or other place)

1-12-98

Hurlock MD Mary C. Yinger-Wife 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hurlock, MD. Md. Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furniral Service Licensee 22. Name and Address of Facility Williamson Funeral Home, Federalsburg, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) Examiner Examiner physiclan and s the buriel-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of) ettending p been signed by the should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No by 24b. Were eutopsy findings eveilable prior to Be Completed 24e. Wes an autopsy performed? completion of cause of death? certificate has birector, page 2 s 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Piece of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA al or Attending Physics efter death.

Il Director: After this ed in by the funeral d this Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed Box 68760 P.O. Records, Division of Vital To the Hospital o within 24 hours of To the Funeral Dicompletely filled in

Baltimore, Maryland 21215-0020

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certil

JAN 1 3 1998

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Crowley, 508 101 Michael D. C 31. Date filed (Month, Day, Year) 508 Idlewild Avenue, Easton, MD. 21601

Julia Davidson Randall

78. 1. 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death **Physician** Month 8:50 A.M. FRANK YOCCABEL 4b. City, Town, or Location of Daath 21 1998 /Medical 4e. Fecility Nama (If not institution, giva street and number) 4c. County of Death Examiner HOSPITAL If Under 1 Glen Burnte ar If Under 24 Hrs. 8. Date of Birt Month, De HRUNDE ANNE NORTH ARUNDEL 6. Sex 12 M 2 ☐ F 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Age (In yrs. last birthday) Year Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 717-12-6304 80 Yrs Director OCT. 21, 1917 PENNSYLVANIA Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits re 23a or 28a-f show MARYLAND ANNE ARUNDEL GLEN BURNIE Director 1 ☐ Yes 2 X No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 40 LINWOOD AVENUE 21061 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armad Forcas? 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner 1X Yes 2 No 1942-If Yes, Giva Year or Dates: 1946 1 Naver Married 2 Marriad ò 1 ☐ Yas 2X No Specify: WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced 1946 Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Hygiene. College (1-4or 5+) 10 GENERAL MOTORS N/A ASSEMBLY LINE WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be 1 PETE YOCCABEL MARY ROSSELLI 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) of Heelth a MRS. GRACE M. YOCCABEL (WIFE) 40 LINWOOD AVENUE, GLEN BURNIE, MD. 21061 other 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cramation 3 ☐ Removal from State = 6 important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) SAINT VITUS CEMETERY 1/26/98 NEW CASTLE, PA. 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate nterval Bet Onsat and Death **Physician** /Medical CONGESTIVE Immediate Cause (Final HEARY diseese or condition resulting in deeth) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Last Due to (or es e consequence of) Box 68760. Physician/Medical the Dua to (or es a consequence of): signed by the et Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Pert i. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably A Unknown Records, by 24b. Were eutopsy findings available prior to completion of ceuse of death? Completed 24a. Was en eutopsy performad? page 2 2 No certificate 1 Yes 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attanding Physician: Be 25. Was cese referred to medical 26. Place of Death (Check only one) examiner? Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No Other: 4 Nursing Homa 5 Residence 8 Othar (Specify) Certification: To 1 Yas this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation efter death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the cause(s) end manner es steted.

2 Medical Examiner: On the bests of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and dua to the ceuse(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certiflar 29c. Licansa number 29d. Date signed (Month, Dev. Year) MA

State Registrar

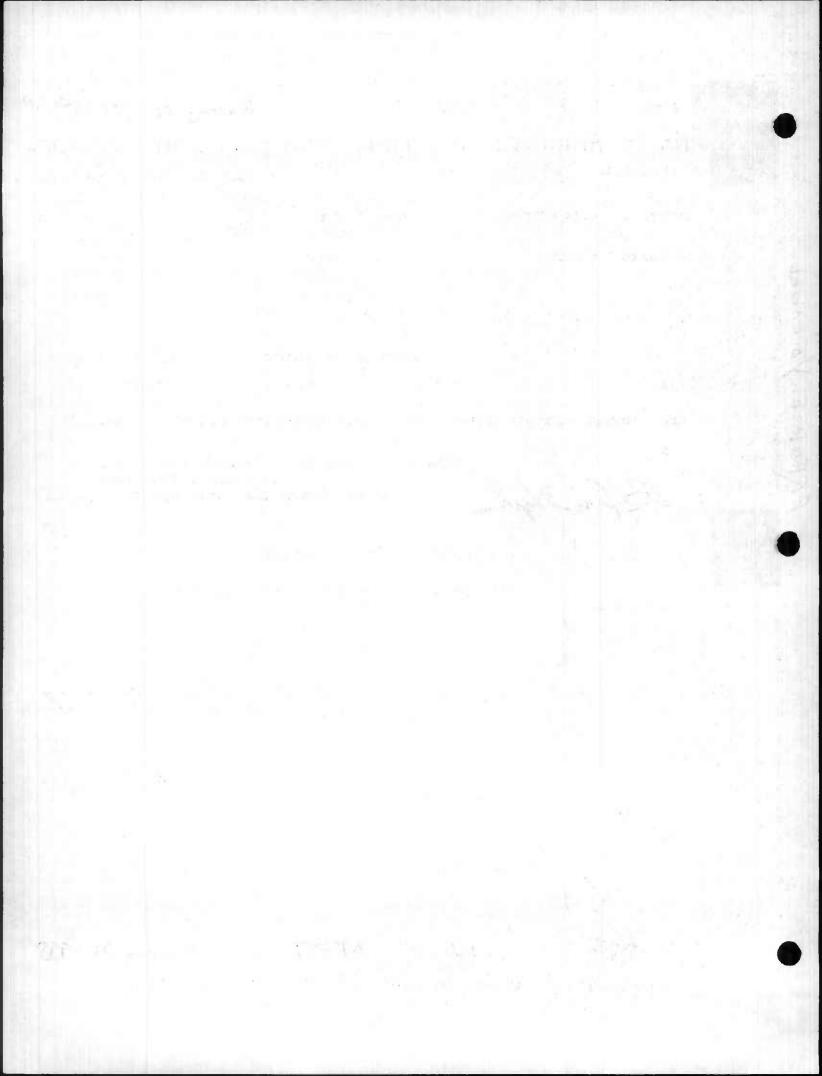
31. Date filed (Month, Day, Year) JAN 22 1998

Copker Original

30, Name and eddre

ss of person who completed cause of deeth (Item 23e) (Type, Print)

30/ Hozpital Drive, Glen Businte. mo 2106/ 32. Registrar Signature Junia Davidson-Randelle

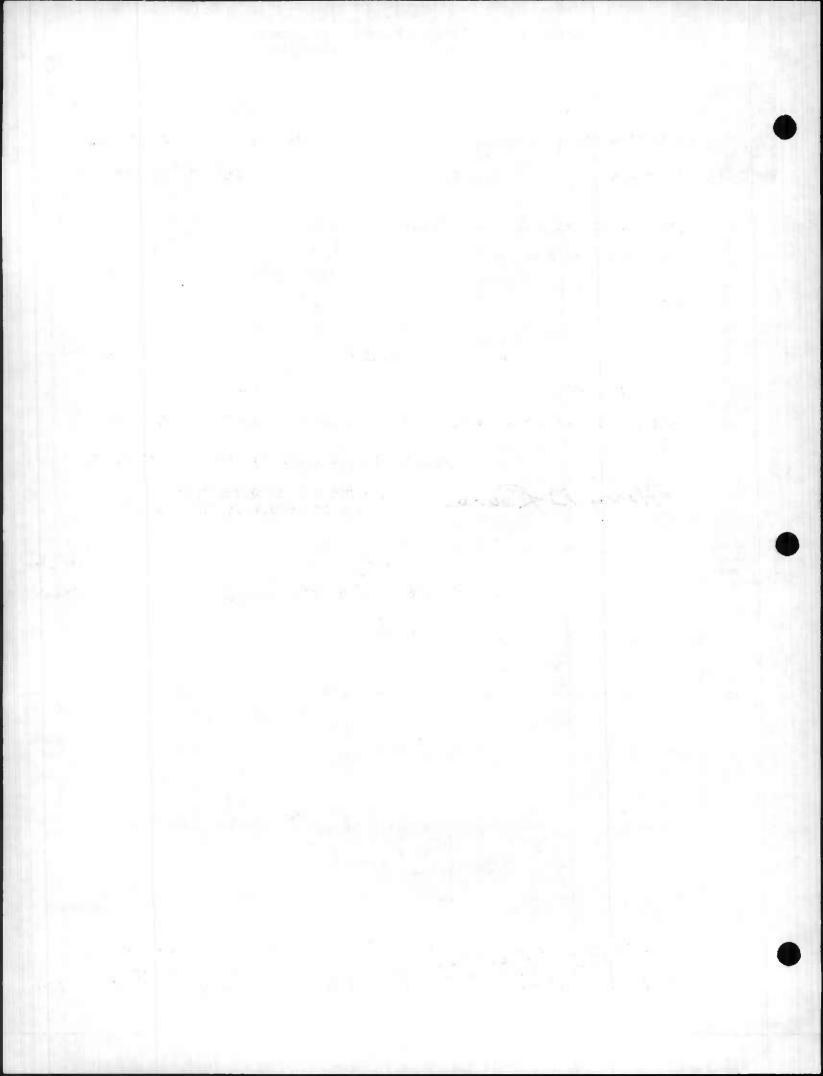


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** VIOLA 20 1998 6:00 pm JAN. /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ANNAPOLIS NURSING & REHAB. ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) 9. Birthplace (St Country)

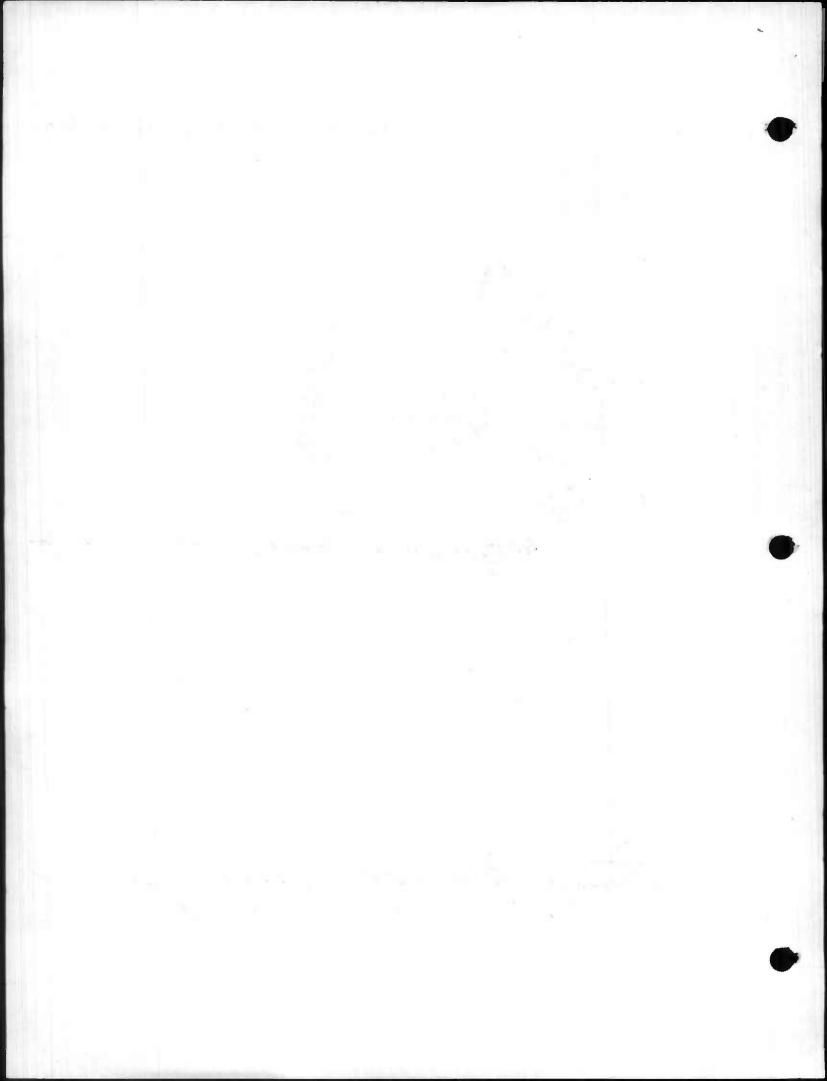
JULY 29 1902 MARYLAND 9. Birthplace (State or Foreign **Funeral** Months Deys 1 ☐ M 2 🗓 F Yrs. Director 95 220-03-9640 Usuel Residence of Decedant the Meryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or itema 23e or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 X Yes 2 □ No MARYLAND ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? US 21401 1822 E. COPELAND STREET death Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxican, Puerto Ricen, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, Whita, atc. 72 hours after 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced by Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elemantary/Secondary (0-12) Collaga (1-4or 5+) OUT SIDE THE HOME 4th 0 DOMESTIC 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumeme) Be 2 should be fi UNOBTAINABLE MARAGRET Lo 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 st Department of Health and Important: If item 27 is n any injury or other traun 1822 E. COPELAND ST. ANNAPOLIS, MD. 21401 MARY S. THOMPSON (GREAT NEICE) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 1/26/98 4 ☐ Donetion 5 ☐ Other (Specify) ANNAPOLIS MEM. GARDENS ANNAPOLIS, MD. 21. Signetura of Funeral Service Licensee 22. Nama end Addrass of Fecility WM. REESE & SONS MORTUARY, P.A. Harri .00 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or raspiretory errast, shock, or heer feitura. List only one ceuse on aech lina. Approximata ntervel Between Onset end Deeth **Physiclan** /Medical Immediate Ceuse (Final diseese or condition rasulting in death) Examiner Examiner buriel-tran Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury pue Box 68760 physician certificate be Physician/Medical the thet Initieted events resulting In death) Lest 98 use for signed by the e Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert f. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records. p 24b. Wara autopsy findings eveilabla prior to completion of cause of death? 24a. Wes en eutopsy performad? Completed peen hes pege 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attanding Physicien: 24 hours efter death. Funeral Director: After this certifice director, 25. Was cese referred to medical Be 28. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) 1 Yes 2 No funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be datarminad 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicida To the Hospital c within 24 hours en To the Funeral D completely filled in 29a. Cartifiar Medical 烤 Certifying Physician: To tha best of my knowledga, daeth occurrad et tha tima, data and placa, and dua to the causa(s) and mannar as statad. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Dey, Year) who completed causa of de (Itam 23a) (Typa, Print) Hochman 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State JAN 22 Registrar



Shan Shan

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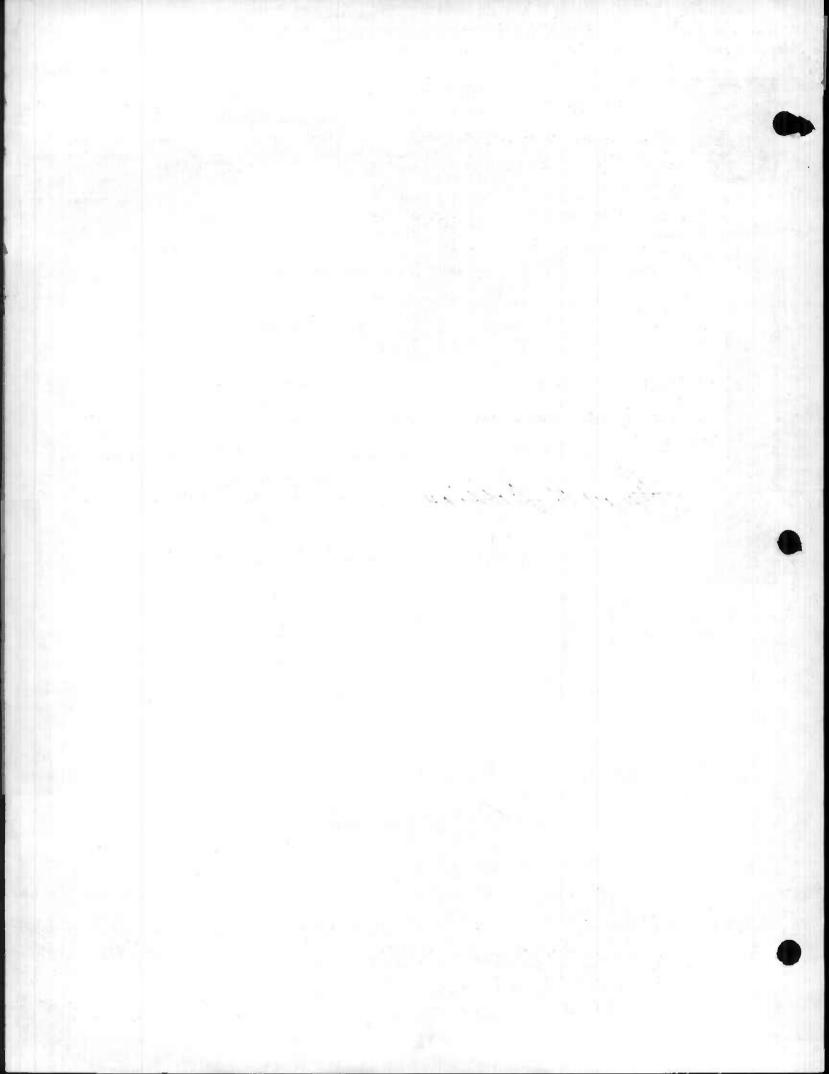
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	1. DECEDENT'S NAME (First,	Middle, Last)	VOITH		ZA	HL	E	DEA	Н	2. DATE MONT	REG. NO.	* 9	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 103-28-259		5. SEX 1 M 2 F	6. AGE (In yrs.	lest birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE (Mont) AUG	25 193	35	8. BIRTHI Country	PLACE (State or Foreign NY
TOR	9a. FACILITY NAME (# not in 263 CONG	RESSIC	NAL LANE	#610				ILLIE		ATH			TGOM	
DIRECTOR	10a. STATE MD	10b. COUNT	TGOMERY			ry, town o								10d. INSIDE CITY LIMITS? 1X YES 2 NO
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В	11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 27	ARMED		tf yes, sp	ENDENT Cooking Cube	OF HISPAN In, Mexices Specify	n, Puarto	i? (Specify Yea Rican, etc.)	or No-	Black	- American Indian, , White, atc. y: WHITE
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ш	17. FATHER'S NAME (First, M CARL ZAH								HER'S NAI		Middle, Maiden	Sumame)		
TO B	19a. INFORMANT'S NAME (7 ZELLA ZA			0							ber, City or Town			852
	20a. METHOD OF DISPOSIT 1	(Specify)		20b. PLAC cometery. CEI	CE AND DATE CREME TO Y OF A	RK C	EMET	ERY		1/20		ESTW(
	21. SIGNATUSE GP SUNERA	1/1	5			DA 11	NZAN 70 F	OCKV	GOLD	BERG	E. ROC	KVII.	LE M	ELS INC D 20852
	23. PART I. Enter the d shock/ or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart failury.	List only one cet	ise on each i	ine.	not enter	tha mo	de of dy	ing, auct	h aa car	diac or reapi	ratory arr	reat,	Approximeta Intervel Batween Onaet and Death ACUTE
ERTIFICATION	Sequentially list condit if any, leeding to imme cause. Enter UNDERLY CAUSE (Disease or Inju that Initieted events resulting in death) LAS	diete ING Iry	C	(OR AS A CON										
MEDICAL C	PART II. Other significe	ent condition	ns contributing to	death but no	ot resulting	in the ur	nderlyin	g cause	given in	Pert I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN:	DID TOBACCO U 25. WAS CASE REFERRED T EXAMINER?		RIBUTE TO CA		LACE OF DEA		only one)] UNC	ERTAIN	1 2				
PHYSICIAN:	YES 2 NO 27. MANNER OF DEATH 1 Netural 5	Pending	1 Inpatient 2 28a. DATE OF (Month, D	INJURY	28b. TII	4 🗆 Nur	28c. INJ WC	RK?			or (Specify) SCRIBE HOW to	NJURY OCC	CURED	
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COMPLETED			ICIAN: To the best of											and manner as stated.
TO BE C	e96-SIGNATURE THE HITLE	OF CERTIFIE	Selle	eyle	11	10	?	29c. LIC	F I	OP	9	29d. DAT	F N	(Month, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene

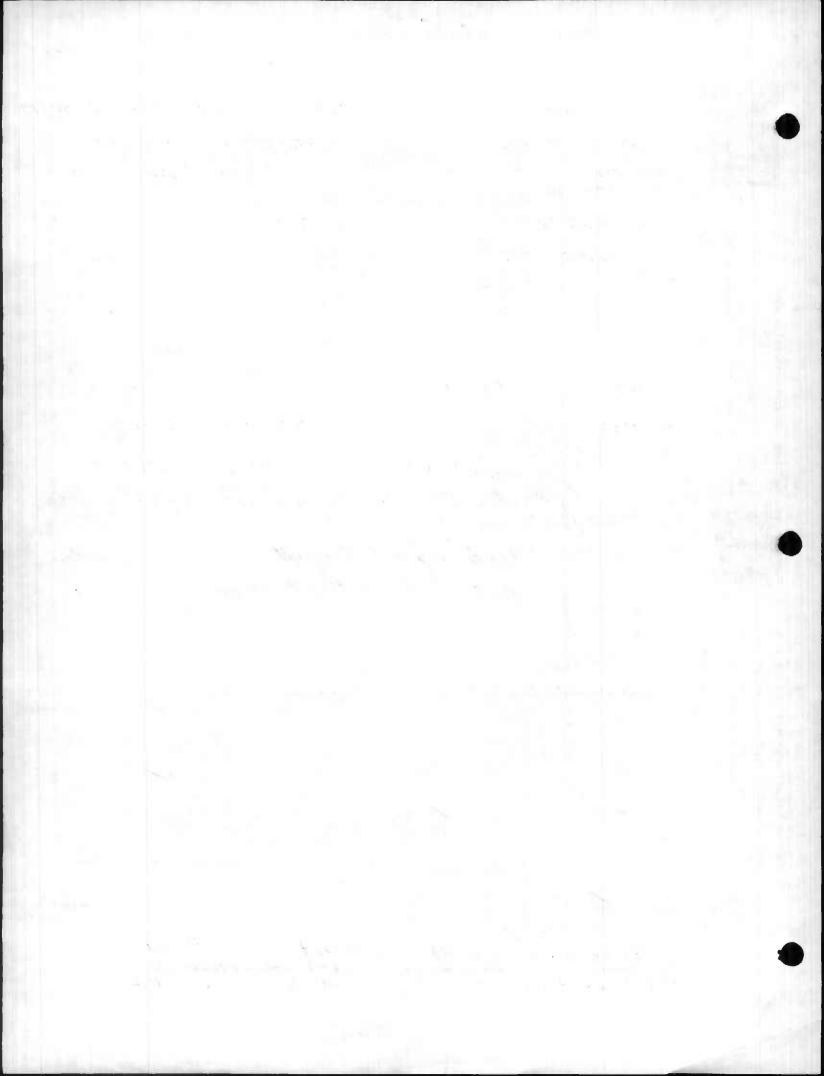
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walalan	ľ	I. Decedent's Nama (First, Middle, L	ast)		100			2. Date of Da Month	ath	V	3. Time of	Death
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aminer	4	a. Facility Name (If not institution, g					4b. City, Town, o	or Location of Deat	h 4c. Cou	nty of Death		- 17
	L	Prince Georges	Community	Hospi	tal		Chever	ly	Princ	e Geo	rges	
eral etor		577-23-5524	Sax 1□ M 2□XF	Aga (In yrs. I 52	ast birthday) Yrs.	If Undar 1 \ Months D	aar If Undar 24 H ays Hours M		th y, Year) 5,1945	9. Birthi Cou Eth	place (State or ntry) iopia	r Foreign
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In P				1	, Town or Lo						10d. Inside Cit	
notified at	-	Maryland Montgom	ery	Tak	toma Pa						X Yes	2 L No
al D	1	0e. Street and Number 24 Manor Circle	#108			10f. Zip Co 2091			10g. Citizen o		ntry?	
by Eu	1	Marital Status Nevar Married 2 Married Widowed 4 Wivorced	12. Was Daceden Armed Forces 1 Yas 2 H If Yes, Giva Year or Dates	No	H	Vas Deceden Yes, specify	of Hispanic Origin? Cuban, Maxican, Pud No Specify:	(Specify Yes or No erto Rican, etc.)	Spec	laca - Americ liack, White, cify: B1		
rt, the Medical Completed		15. Decedent's E (Specify only highest gi	ducation		16a. Deced	ent's Usual O	ccupation	unding	16b. Kind of	Business/In	dustry	
Me du	-	Eiementary/Secondary (0-12)	Coilege (1-4or	5+)			one during most of watered)	vorking				
Comp	-		2		House	wife			Home	2		
Be C		7. Father's Name (First, Middle, Las	•					lame (First, Middle,	Malden Sum	ame)		
	L	Zewodie Achamyel	eh				Desta	Arrso				
other traumatic	1	9a. Informant'a Name/Relationship		,	19b. Mailin	g Address (S	reet and Number or	Rural Routa Numbi	er, City or Tox	vn, State, Zip	Code)	
10 10	-	Solomon Asefa (son in lav				rcle #108	, Takoma	Park,	MD 2	0912	
6	2	0a. Method of Disposition 1 ☒ Burial 2 ☐ Cremetion 3 [4 ☐ Donation 5 ☐ Other (Speci		CE	metery, crem	sition (Name of latory or other Cemet	place)	Date 1/17/98	20c. Locatio Washi		, D.C.	
nny injury	1	1. Signature Fanarai Sarvice Lice		4	-22	Name and A	ddress of Facility					
8 8		Atten 1 A	1 11	1.			funeral S rgia Ave.				0.01	0012
rial-transit and Examiner	1	liseasa or condition esulting in death) Sequantially list conditions, any, leeding to immediate ause. Enter Underlying Jause, (Disease or injury	a. / V (#\$>>		as a consequence as a c		SWALL	Acid	En Y			
datached for use as the bunal-transit Physician/Medical Examir	1 1	Cause (Disease or injury net initiated events essulting in deeth) Lest	d	Due to (or	as a consequ	anca of):				-		
/sic	P	art II. Other algnificant conditions	contributing to death I	but not resul	lting in the un	derlying caus	e given In Part I.	23b. Dld 1	tobacco usa	contribute to	the cause of	f death?
be dated	-							10	Yes 27 No	3 □ Prof	bably 4□U	Inknown
2 should	-							24a. Was perfo	an autopsy med?	av. co	ere autopsy fin ailabla prior to mpletion of ca death?	
Com								101	res 2 No	1[Yes 2□ N	No
director,	2	5. Was case referred to medical examiner?					26. Place of D	eath (Check only o	ne)			
		1 Yes 2 No	Hospital:	ient 2 🗆 E	R/Outpatient	3□ DOA	Other:	Home 5 ☐ Resid		ther (Specif	y)	
0	2	7. Manner of Death 1 ☑ Netural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury		Injury at Work? 1 Yes 2 No	28d. Describe h				
complately filled in by the funeral Medical Certification:		3 ☐ Suicide 6 ☐ Could not be determined	286. Place of in	ijury - At hor tc. (Specify)	ne, farm, stre	et, factory, of	ice	28f. Location (5 City or Tox	Street and Nur vn, Stete)	n <i>ber</i> or Rura	I Route Numb	er,
plataly fill	2	9a. Certifier (Check only one) Certifying Pi	nyalclan: To the best niner: On the basis of end menner st	of examination	riedge, death on and/or inve	occurred at the estigation, in r	e time, date and pled ny opinion, death occ	ce, end due to the courred at the tima,	ceuse(s) and r date and place	manner as si	eted. the cause(s)	
¥ Supplier	2	Signature and title of certifier	- (()		29c, Lic	ense number		29d. Date sign	ned (Month,	Day, Year)	
		*X	1	/		5 D	0051097		,/11	100		
	31	Namel and address of person who	completed company	death (Item)	23ah (Tuna B		(1000年) (1000年) (1000年)		1/18	178		
	1	Schothia L. Mc	Sound	M)			pital Dri	ve, Cheve	erly, M	D 20	785	
State	,9	JAN 20 1000	A Regist	rar's Signatu	iro							

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2909

10-100			15359		Cei	tificate of	Death		g. No.	
Physic	ian	Decedent's Name (First, Middle,	Last)					2. Date of Deeth Month	Day Year 1998 4c. County of Death MONTGOME 4c. County of Death MONTGOME 9. Birthp Count 1. Citizen of What Count U.S. 14. Race - Americ Black, White, Specify: WH b. Kind of Business/Inc RNITURE iden Surname) KOWI City or Town, State, Zip RK, MD 20 C. Location - City or To ALTIMORE, Dn & Bros., Seville, MD 2000 21240 3 Prot 24b. We 21240 3 Prot 24b. We 21240 3 Prot 24c. See 6 Other (Specify injury occurred	Year 3. Time of Death
/Medi			LIE			APPI		JAN. 27		5:30 PM
Exami	ner	4e. Facility Name (If not institution,	give street and numb	er)			4b. City, Town, or	Location of Death	4c. County of	f Death
		HOLY CROSS		916			SILVER S			
Funeral Director		217-05-7054	6. Sax 7. 1 □ M 2 F	Aga (In yrs. la 88	st birthday) Yrs.	If Under 1 Yaar Months Days	Hours Min		1909	Birthplece (State or Foreign Country) MD
and w		Usual Residenca of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation			Jay Year 1998 4c. County of Death MONTCOME Year 1909 9. Birthp Coun U.S. 14. Race - Americ Black, White, t Specify: WH Sb. Kind of Business/Ind RNITURE Biden Surname) KOWI City or Town, State, Zip ARK, MD 20 C. Location - City or To BALTIMORE, DON & Bros., PSVIlle, MD 10 11 12 13 14 15 16 17 17 17 18 18 19 19 19 10 10 10 10 10 10 10	10d. Inside City Limits
ath with the Marylan 23a or 28a-f ehow	Director		GEORGE	1.00.01.5,			MA PARK			1 Yes 2 No
ith th	Oire	10e. Street end Number				10f. Zip Coda		10	g. Citizen of Wi	hat Country?
23a	a	7905 LOCKNE	Y AVENUE				20912		1	U.S.A.
items items	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	. 13. V	Was Dacedant of he Yes, specify Cub	lispanic Origin? (San, Mexican, Puer	Specify Yas or No- to Rican, atc.)		
a o	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ☐ Yes 2 If Yes, Give Yaar or Date			I□Yas 2 XX No				WHITE
d within 72 hours af giene. r than "natural", or the Medical Exam	ted	15. Decedent's (Specify only highest			16a. Deced	lent's Usual Occup kind of work done OO NOT use retire	etion	nt ina	6b. Kind of Bus	iness/Industry
S	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	OO NOT use retire	d)	King		
0 0 -	Co	12			UPHOL	STERER		F	JRNITUR	2
	Be	17. Fathar's Nama (First, Middle, Lo	ast)					me (First, Middle, Ma		
	2	MOSES		AP	PLE		TILLIE			KOWITZ
and and is m		19a. informant's Name/Relationshi	p (Type, Print)	9	19b. Mailin	g Address (Street	and Number or A	ural Route Number,	City or Town, S	State, Zip Code)
s 1 and if Health Item 27 other tr		ANNA ROSEN / SI	STER			HAMMOND	AVENUE	TAKOMA PA	ARK, MD	20912
ges 1 it of He if item or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremetion 3	OD-mount from Ste	- 004	nee of Dispo	sition (Name of natory or other pla	ca)	Date 20	Oc. Location - C	City or Town, State
Pages nent of I int: If its ary or o		4 □ Donetion 5 □ Other (Spe		//	I ISR	A FT.		1/20/08	CMTTTAS	DF. MD
permit. Pag Department Important: any Injury once.		21. Signeture of Funerel Service	misoy -	DIVA		. Name and Addre	ss of Fecility			
Dep imp		-	1001/2		_ 8	900 Pais	terstown	ol Levins	on & Br	os., Inc.
		23a. Pert1. Enter the disease, oc shock, or heart failure.	omplications that caus	sed the death.						
Physician		shock, or heart failure. Latto	nly one cause on eecl	h line.						Approximate Intervel Between Onset and Death
/Medical		Immediate Cause (Finel	0.	W		11				- 11
Examiner		disease or condition resulting in death)	a. ucu	we m	up co	raise	your			Juden
	ē		1-	Due to (er	s a conseq	rdial i		2		1-
nsit	튵		. b. TR			1	au o	Blue		399
cate be executed physicien and the burial-transit	Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		Due to (or a	as a conseq	uence of):				
be		Cause (Disease or Injury	C							
ifficate be executed g physicien and es the burial-transit	edicai	resulting in deeth) Last		Due to (or a	as a consequ	uence of):				
	1000		d			MILL D				
death cert e attending ed for use	clar									
ires that the death cer signed by the attendir d be detached for use	Physician/N	Part II. Other algnificent condition	s contributing to deati	h but not rasult	ting In tha ur	nderlying cause gh	en in Pert I.			ribute to the cause of death? 3 Probably 4 Unknow
requires een sign hould be	d by							24a. Wes en	eutopsy	24b. Were eutopsy findings
	ete							perform	ed?	evailable prior to completion of cause of deeth?
has b	Completed									of deeth?
The la								1 ☐ Yes	212No	1 ☐ Yes 2 ☐ No
Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hogeltet		/			ath (Check only one)	
Physic this c	2	1 Yes 2 No	Hospital:		R/Outpatien		4 LI Nursing			
	on:	27. Manner of Death 1 ☑ Naturel 5 ☐ Pending	28a. Dete of i	njury Day Year) 2	28b. Time of Injury	28c. Inju	y at rk?	28d. Describe how	v injury occurre	d
Attending r death. actor: Atte by the fune	cat	2 Accident investiga				M 1	Yes 2 □ No			
or Attendation	Certification:	3 ☐ Suiclde 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of	Injury - At hom etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		r or Rural Routa Number,
100	dical C	29a. Certifler 1 ertifying (Check only one)	Physician: To the be caminer: On the basis and menner	s of exemination	ledge, death on and/or inv	occurred et the tir restigation, in my o	me, date end place pinion, deeth occ	a, and due to the ceu urred et the time, det	use(s) end men e end place, er	ner as stated. nd due to the cause(s)
5	ME	29b. Signature and title of certifier	0 0			29c. Licens	se number	29	d. Pate signed	(Month, Day, Year)
146	1	m.	17. 1		1	0060	174	1,	28/12	9
/		1/1/201 a	sing	a my		0000	00 0110	OKELL	2110	
		30. Name and address of person w	no completed ceuse of	of death (Item 2	23e) (Type, I	Print) 2-3	y offe	NEFIELD	2.003	
		21 Date fled Atout Day	ENKIN	עריי			EMIDA	MD.	2070	
Sta	_	31. Date filed (Month, Day, Year)	3 1998 D	istrar's Signatu	ire					
Registi	ar	LERA	3 1998	Julie 1	CHARLES	70				
MH 16 Rev 6/9	5			U	I VICE III	Manages.				



98-463-510 jhm WALTER CONRAD AUSTIN

> **Physician** /Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		Cer	tificate	of Dea	ath		Reg. N	0.			
1. Decedent's Name (First, Middle, Las	()					2. Date of D	eath		Voor	3. Tim	a of Death
WALTER	AUSTIN					JANUA		ay 30,19	Year 998	23	:57 PM
4a Facility Name (If not Institution, give	street and number)		- 1-1-1	4b. Cit	y, Town, or	Location of Dea			of Deeth		
JOHN HOPKINS HOS	PITAL				TIMORE			N/A	A		
	7. Age (<i>lin yrs</i> .	. last birthday) Yrs.	If Undar 1	Year If U	nder 24 Hrs urs Min.	. (Month, D	irth Day, Yea 4,19		9. Birthp Coun	itry)	te or Foreig
Usual Residence of Decedent 10a. State 10b. County	10c. C	ity. Town or Lo	cation						1	Od. Insid	e City Limits
MARYLAND N/A				TOR?							res 2□No
10e. Street and Number		DALITI	10f. Zip C				10a. C	itizen of	What Cour	trv?	
1015 N. CAROLINE	STREET			205				U.S.			
11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V			ic Origin? (S	Specify Yes or N	lo-		ce - Amaric	an India:	٦,
1 Never Married 2 Married	Armed Forces?		Yes specify	Cuban, Me	xican, Puar	Specify Yes or N to Rican, etc.)		Bla	ck, White,	etc.	
3 ☐ Widowed 4 ☑ Divorced	17 Yas, Give Year or Dates: SEP	1	19772	No Spe	ecify:			Specify: NEGRO			
15. Decedent's Edu		16a Deced	lent's Usual (Occupation		d for	16b. Kind of Business/Inde				
(Specify only highest grad	College (1-4or 5+)	life. C	kind of work OO NOT use	aone auring retired)	most of wo	rking					
11TH	N/A	LAND	SCAPI	NG				PF	RIVATI	E CO	
17. Father's Name (First, Middle, Last)				18. N	Mother's Na	me (First, Middl	le, Maide	n Suman	me)		
HERBURT R. MCG	lotten				Mary	Austin	1				
19a. fnformant's Name/Relationship (T	ype, Print)	19b. Mallin	g Address (S	Street end N	lumber or R	ural Route Num	ber, City	or Town	, State, Zip	Code)	
MARY NELSON /	MOTHER	1015	N. CAI	ROLINE	ST.	BALTO.	MD.	21	205		
20a. Method of Disposition		Placa of Dispos cametery, cren	sition (Name	of		Date	20c.		- City or To	own, Stat	ө
1 Burial 2 Cremation 3 1 4 Donation 5 Other (Spacify,		SHELL M	MEMORIA	AL GAR	DENS	JAN. 7	190	8 RA	ATJTO.	MD	
21. Significant of Funeral Service Licens	fresage.	1/	CALVIN		RUGGS	FUNERA			MD	212	
23a. Part 1. Enter the diseasa, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that gaused the dea	As c	CALVIN 1412 I er the mode o	B. SC	RUGGS	STREET	BAT	ME LTO,	MD.		L3 mate Between and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physicial and completely filled in by the funeral director, page 2 should be deteched for use as the Quial-tran

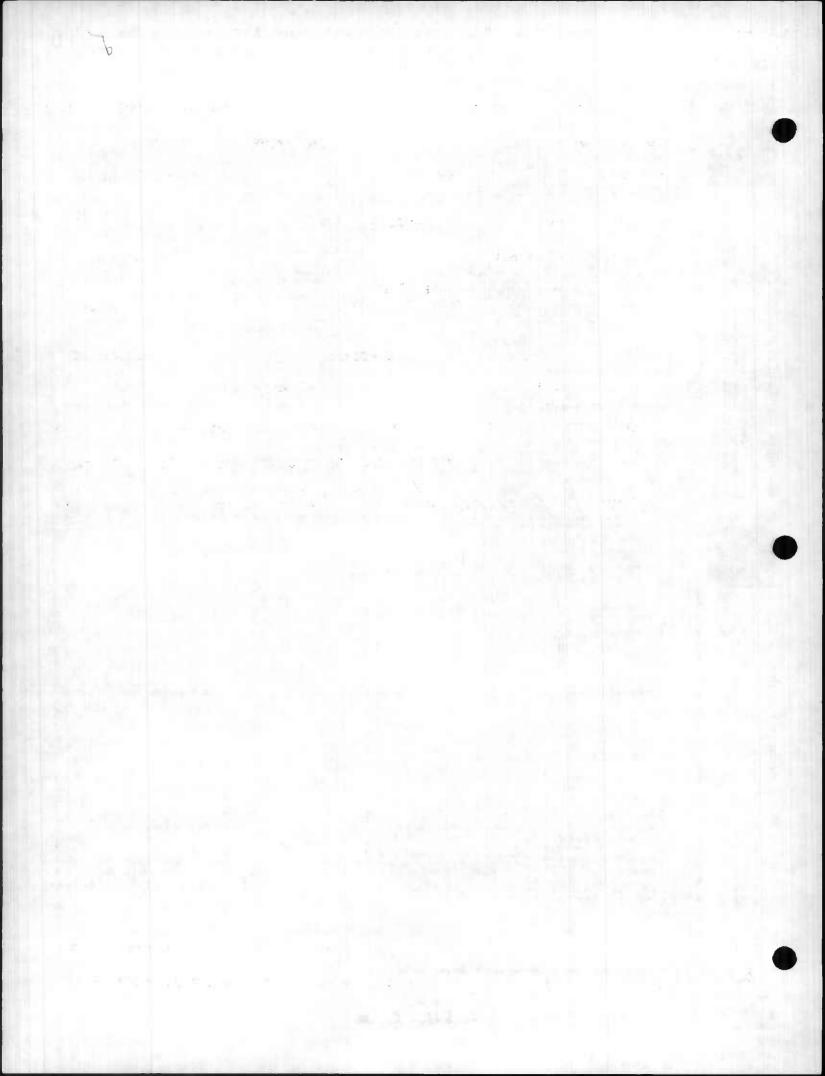
Division of Vital Records, P.O. Box 68760,

Registrar

Stephen 5, 31. Date filed (Month, Day, Year)

Radentz

ta Savidson Randall

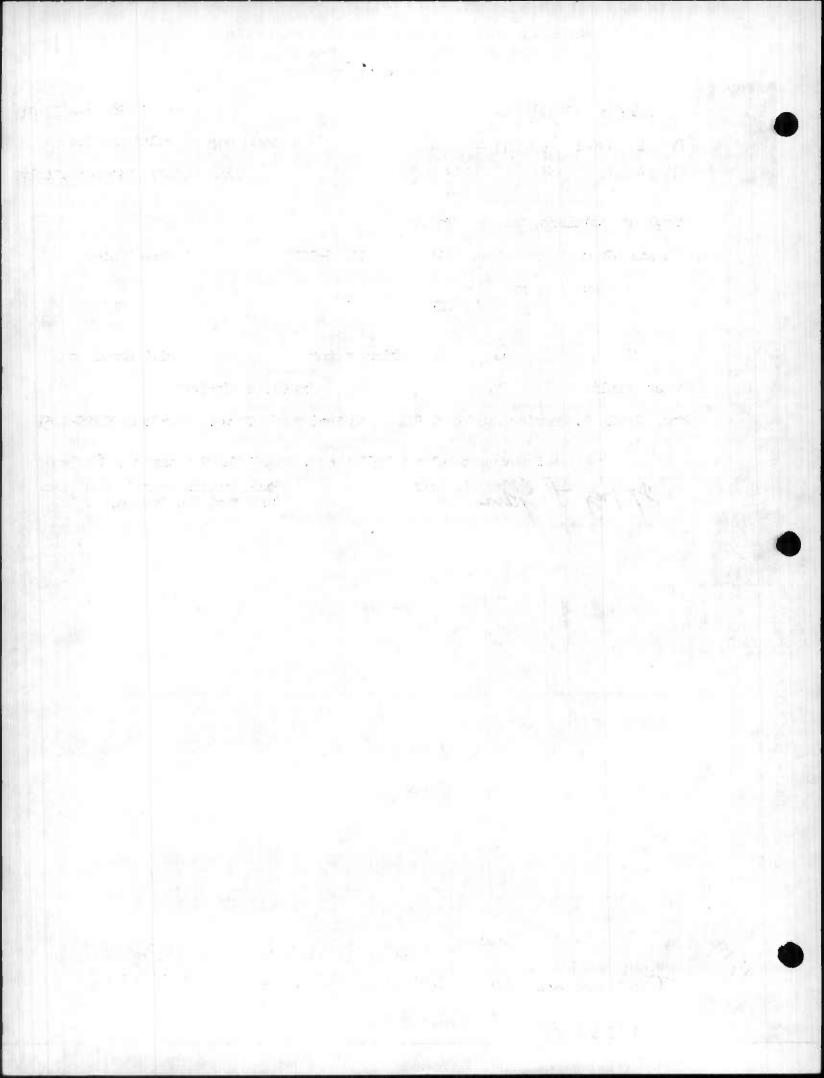


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month Agualia Joseph 0 /Medical 4e. Fecliity Nema (If not institution, giva sweet and number, 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Health Services Baltimore Co. lowson, MD MANOR CARE | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth (Months, Day, Year) | NOV 25,1911 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplece (Stata or Foreign **Funeral** 1 M 2□ F Vittoria, Italy 217-18-3611 86 Yrs. Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumetic event, the Medical Examiner rount be notified at Director 1 ☐ Yas 2 ☐ No Maryland Baltimore Co. Towson 10e. Street end Number 10f. Zip Code 10g, Citizan of Whet Country? or items 23a 205 East Joppa Road Apt. #2404 21286-3233 United States Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican indien, Black, White, etc. CXDX'as 2 □ No If Yes, Giva Year or DatesW.W.II 1 Never Married 2 Narried Baltimore, Maryland 21215-0020 1 Yas 2X No by Specify: 3 Widowad 4 Divorced "natural", White Completed 16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry Pages 1 and 2 should be filed within nent of Health end Mental Hygiene. Int; If Item 27 Is marked other than "rivy or other traumatic event, trained. Elementery/Secondery (0-12) College (1-4or 5+) 06 Health Services Chiropractor 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Aguglia Josephine Vindigni 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mrs. Gloria A. Merriam (Daughter) 912 Stags Head Road Towson, Maryland 21286-1461 20b. Plece of Disposition (Nema of cemetery, cremetory or othar place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata permit. Page Department of Important: If any Injury or once. 4 Donetion 5 KOther (Specify) Entombment Dulaney Valley Mem. Gard. 02/04/98 Timonium, Maryland 22. Neme end Address of Facility Ruck Towson Funeral Home, Inc. Jeffrey L. Gair an 1050 York Rd. Towson, Md. 21204 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immadiata Cause (Finei disease or condition resulting in death) 1 day Examiner Due to (or es e consequence of): Physician/Medical Examiner aspiration be executed Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Dua to (or es e consaguence of) 68760. stroke The lew requires that the death certificate the Due to (or es e consequance of): θS Box P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 8 page 2 should 24b. Ware eutopsy findings eveileble prior to completion of causa of deeth? Completed 24a. Was an eutopsy performed? heart Nhea of Vital disesse 25. Wes cese referred to medical exeminer? Physician: director, Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetiant 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To the funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After Division or Attending 5 Pending Investigation 1 Naturel s efter death. NA 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be in by t 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours e To the Funeral C Hospital 1 Certifying Physictan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medicat Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner steted. 29a. Certifier Medical (Check only one) the 29b. Signetura and title of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) ans 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) York Pd Towson WD 21204 MD 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signeture State Registrar

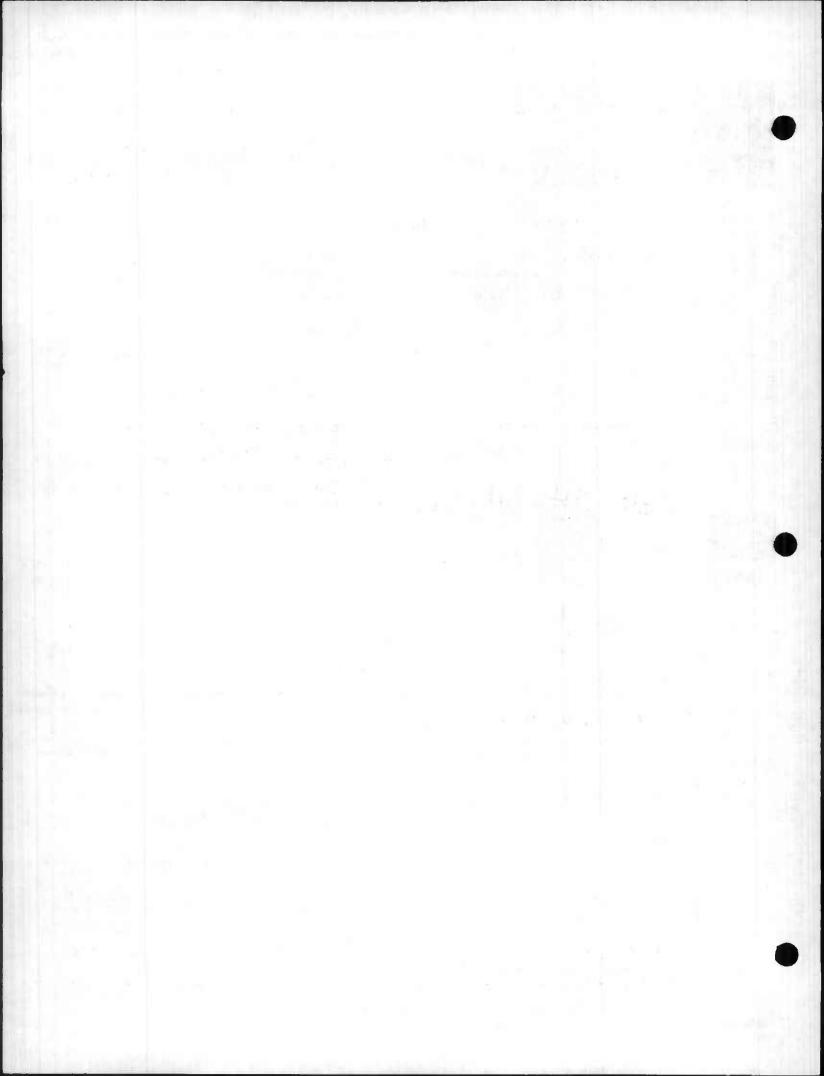
DHMH 16 Rev 6/95

Lulia Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22912

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 16b per FH Film G756 2-3-98 rja Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Death 3. Time of Death Yeer **Physician** 200 es Rainia CONSTANCE 30,1998 LAMUAY /Medical 4e. Fecility Neme (if not institution, give street and number) 4b City, Town, or Location of Deeth/ 4c County of Deeth Examiner Daltimore Baltimore Mospita Rat 5. Sociel Sacurity Number | If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth | Months | Deys | Hours | Min. | Month, Dey, Year 9. Birthplaca (State or Foraign Country) 7. Aga (In yrs. lest birthdey) 6. Sex **Funeral** Deys Hours 1 M 2 DE 218-18-8594 7 5 Sep. 15 1922 Director Usuel Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "naturel", or items 23s or 28s-f sho treumatic event, the Medical Examiner must be neutral at Md Baltimore 1 TYS 2 No Director NA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? W. Latan 2515 ette 21214 USA Funeral 12. Was Decedent Ever In U.S. Armed Forcas? 11. Marital Status 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Biack, Whita, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 NHO
If Yas, Giva
Yaar or Detes: Black 1 Yes 2 No Specify: 3 Nidowed 4 Divorced by Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry WESTERN HOUSE Elementery/Secondery (0-12) College (1-4or 5+) 12+h DERRITOR LINE 0 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fethar's Name (First, Middle, Last) Be KODE2+ 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Balto James B. BROTHER 3007 W. Lanuale St Md 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 Burial 2 Crametion 3 Removal from Steta Salto 2.5.98 butus 4 ☐ Donetion 5 ☐ Other (Specify) Hem. Pork Funeral Home West INC of Funaral Service Licensee 22 Name end Addrass of Facility Umc March 1 Balto. Luc 23a Part . Entar the ulsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta Intervel Between Onset end Deeth **Physician** /Medicai Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): 103d Levole Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 1 No 1 Tas 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Pleca of Deeth (Check only one) exeminer? 1 Nes 2 No Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Mennar of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Nature 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

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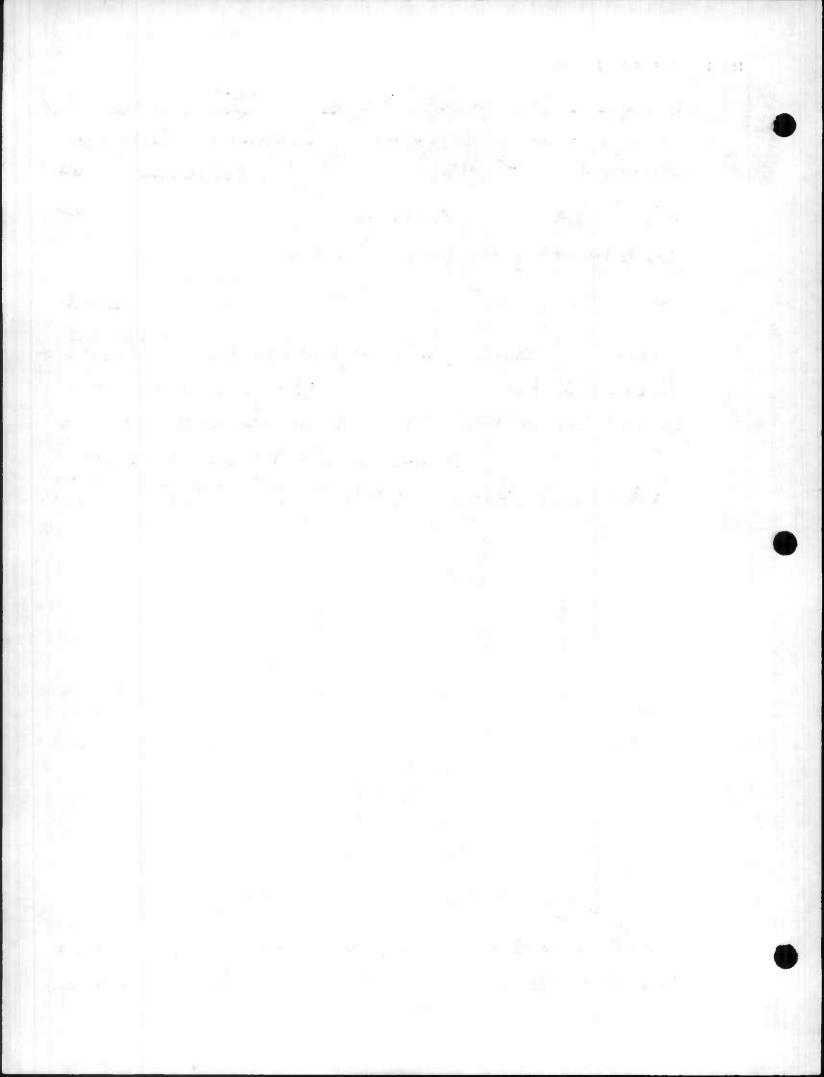
onne 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) - Ill Hamlet 32 Registrar's Signetura 31. Dete filed (Month, Dey, Year) 3 1998

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as steted.

2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner steted.

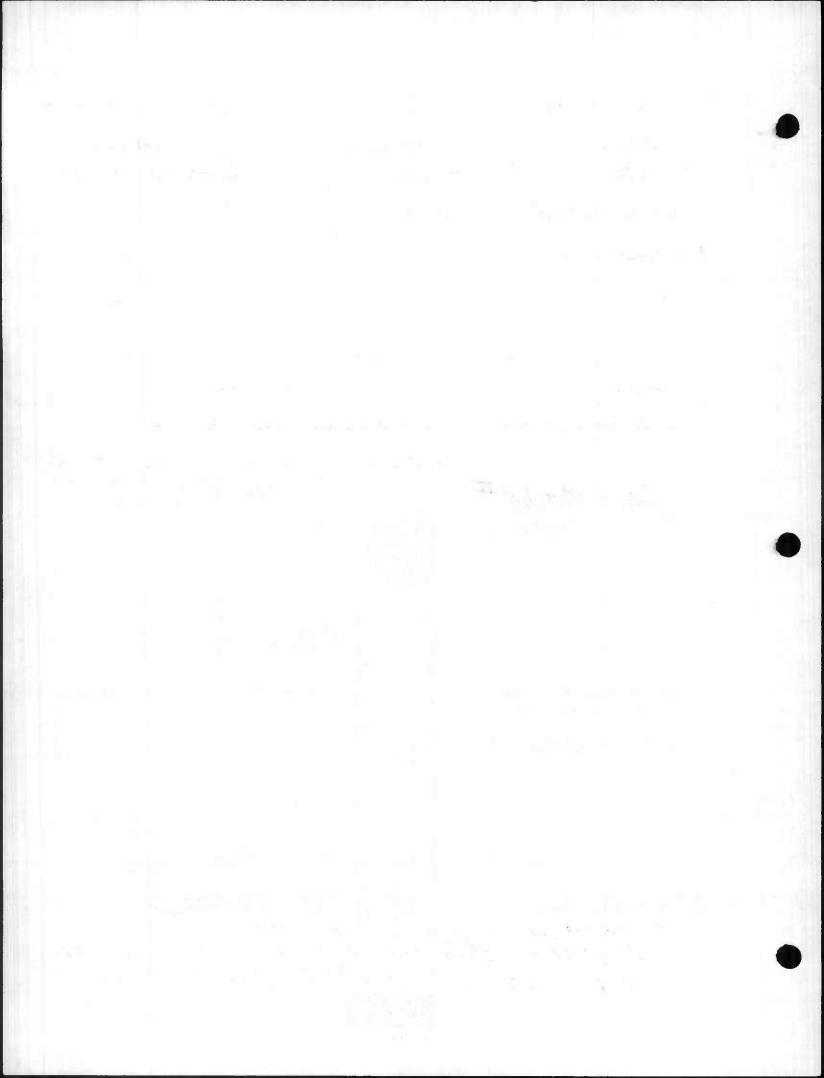
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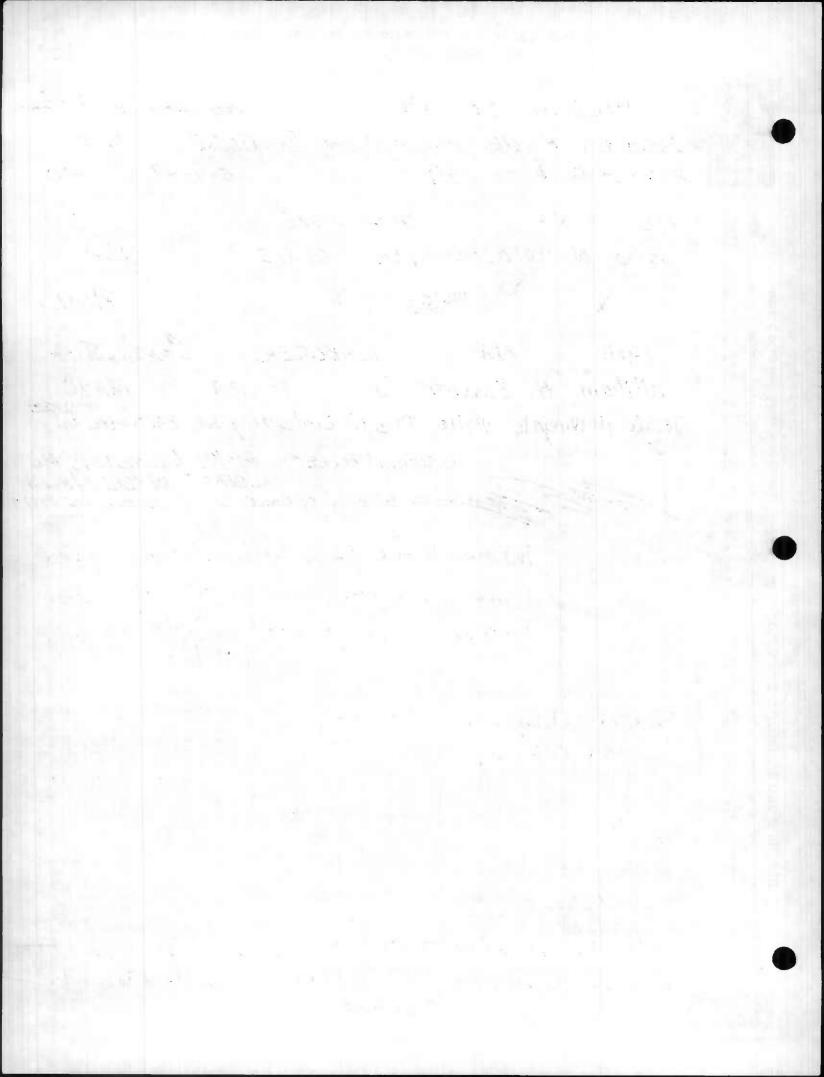
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 2/20/98 dh Certificate of Death Items: 2,3 per MD G-756 2/20/98 dh Item: 29d per MD G-756 Reg. No 2. Date of Death Feb. 1,1998 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:45 pm **Physician** William /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Knolls 7. Age (In yrs. last birthday) If Under 1 Yea ISALI If Under 24 Hrs. MORE 5. Social Security Number 6. Sex-1 M M 2 □ F 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 216-28-1490 Usual Residence of Decedent Director the Meryland 10e State 10b. County 10c. City, Town or Location 10d. Inside/City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Modical Examinator must be notified at BALTIMOR 1 Yes 2 No Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with SPRING Funeral 12. Was Decedent Ever in U.S. Amed Forces?
1 M Yes 2 D No 11 M Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiene. Introductant: If Item 27 is marked other than "natural", or flen any Injury or other traumatic avent 1 ☐ Never Married 2☐ Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify Blac þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15 Decedent's Education 16b. Kind of Business/Industry ontiary (0-12) Collega (1-for 5+) 27 ABOREK ONStr 17. Fether's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1/2/5 19a. Informant's Name/Relationship (Type, Print) 3906 Coldspring BALTIMORE, Dister N Jessu 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data N Burial 2 ☐ Cremation 3 ☐ Removal from State 2/5/98 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 2. Part 1. Enter the disease, or complication and the deeth. Do not enter the mode of dylng, such as cardiac or respiratory shock, or heart failure. List only one diuse on each line. Approximata Interval Batween Onset end Death **Physician** /Medical Immediate Cause (Final gratio lascalar disease or condition Examiner Examiner eider Vascular ettending physician end for use as the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, n Physician/Medical to (or es e consequence of): use as t Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? certificate has b 1 Yes 2 No 25. Was case referred to medical examiner?
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27. Manner of Daath Be 26. Placa of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred 1 Natural
2 Accident Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No ofter deetl Director: 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida 0 To the Houls within 24 houls To the Funeral Completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifiar Medicai (Check only one) 29d. Date signed (Month, Day, Year) 1998 29b. Signature and title of certifier lacem 30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print)-X 01 32. Registrer's Signature
Julia Davidson Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

-	0	0		-
11	1	Q	1	10
13	600	1	1	0

BOONE **Physician** /Medical

1. Decedent's Name (First, Middle, Last) Alice E.

Boone

2. Date of Death JANUARY 28, 1998

3. Time of Death 4:29P.M.

Examiner

Director

þ

Completed

Be

4a Facility Neme (If not institution, give street end number) 1511 W.OLD COLD SPRING LANE 4b. City, Town, or Location of Death BALTIMORE

4c. County of Death

Funeral Director

7 is merked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: if item 27 is marked other 1 any Injury or other treumatic event.

Physician

Examiner

/Medical

physician end the buriel-tran

88 950 Po

signed t

page 2 hes

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certificate

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After

after death.

24 hours a Hospital

To the Vithin 2 comple

Attending Physician:

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certificate be

Examiner

Physician/Medical

by

Completed

0

Certification:

edical

5. Social Security Number 1 M 2 X X 217-76-8858

7. Age (In yrs. last birthday) if Under 1 Year Months Days

10f. Zip Code

If Under 24 Hrs. 8. Date of Birth Hours Min. May 16, 1911 9. Birthplace (Stete of Country) May 16, 1911 Mary 1 and 9. Birthplace (Stete or Foreign

the Maryland

Maryland 21215-0020

Baltimore,

10a State 10b. County Maryland N/A

Usual Residence of Decedent

10c. City. Town or Location Baltimore 10d. Inside City Limits 1X□XYes 2□ No

10e. Street and Number

1511 W. Old Cold Spring Lane

86

21209

10g. Citizen of What Country? USA

Funeral

1 ☐ Never Married 2 ☐ Married X□XWidowed 4 □ Divorced

12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Year or Dates:

13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

20c. Location - City or Town, Stete

12

Elementery/Secondary (0-12)

Homemaker

Own Home

17. Fether's Name (First, Middle, Last) Eden Hedrick

18. Mother's Name (First, Middle, Meiden Sumeme) Beulah Fisher

Date

in-law 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print) Brother - 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
LOUIS C. Johnson in-law 1325 Medfield Avanua Paltimona 1325 Medfield Avenue, Baltimore, Md 21211

4 Donation

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify)

Druid Ridge Cemetery 2/2/98 Pikesville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Burgee-Henss Funeral Home

23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac of respiratory arrest, Approximate shock, or heart failure. List only one cause on each line.

. Athoroscleronz lardiaruscular disease condicared

Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

new. injury Due to (or as a consequence of):

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

Purhar 1 Yes 2 □ No

26. Place of Death (Check only one)

1 Tres 2 No

25. Was case referred to medical examiner? No Yes 2 No

27. Manner of Deeth 1 Natural 5 Pending

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (28b. Time of (Month, Dey Year) 1-29-98 investigation 16 22

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 54 5/200 fell down Shuirs

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1511 Wold cold spring

29a. Certifier (Check only one)

2 Accident

4 Homicide

3 ☐ Suicide

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Dey, Year) JANUARY 29,1998

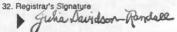
30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Powder 31. Date filed (Month, Dey, Yeer)

111 Penn Street, Baltimore, Maryland 21201

Registrar

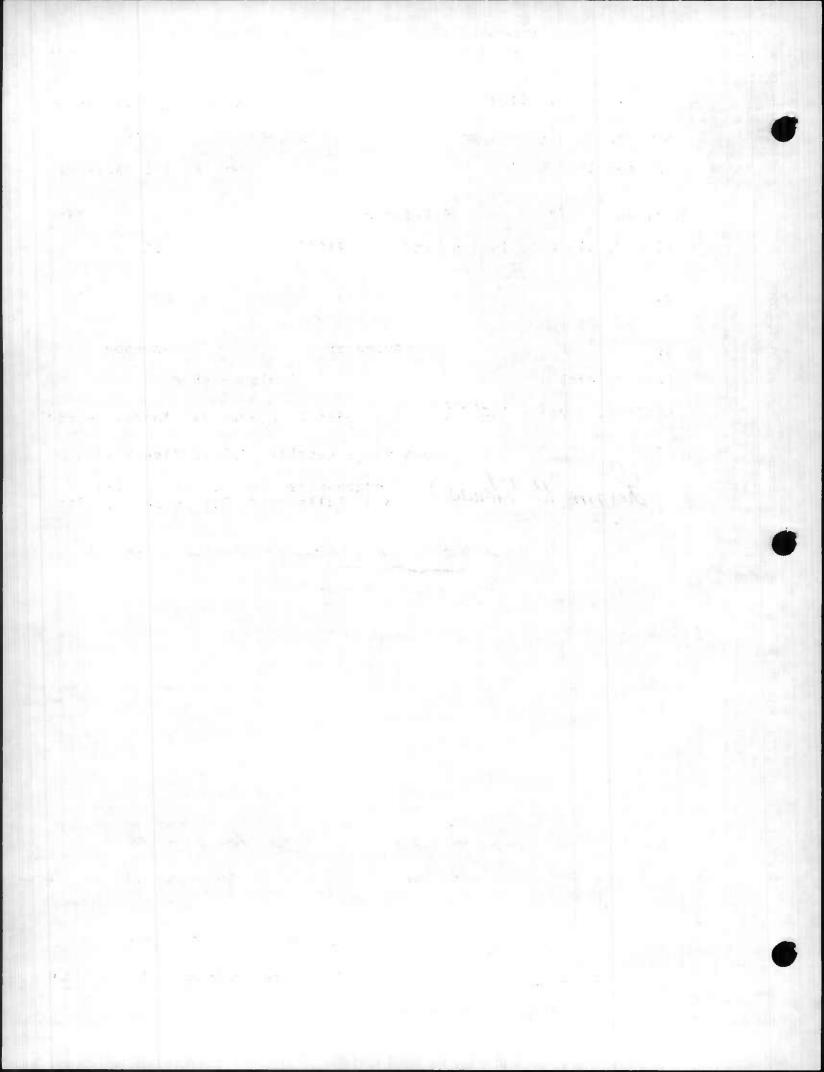
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Division of Vital Records,

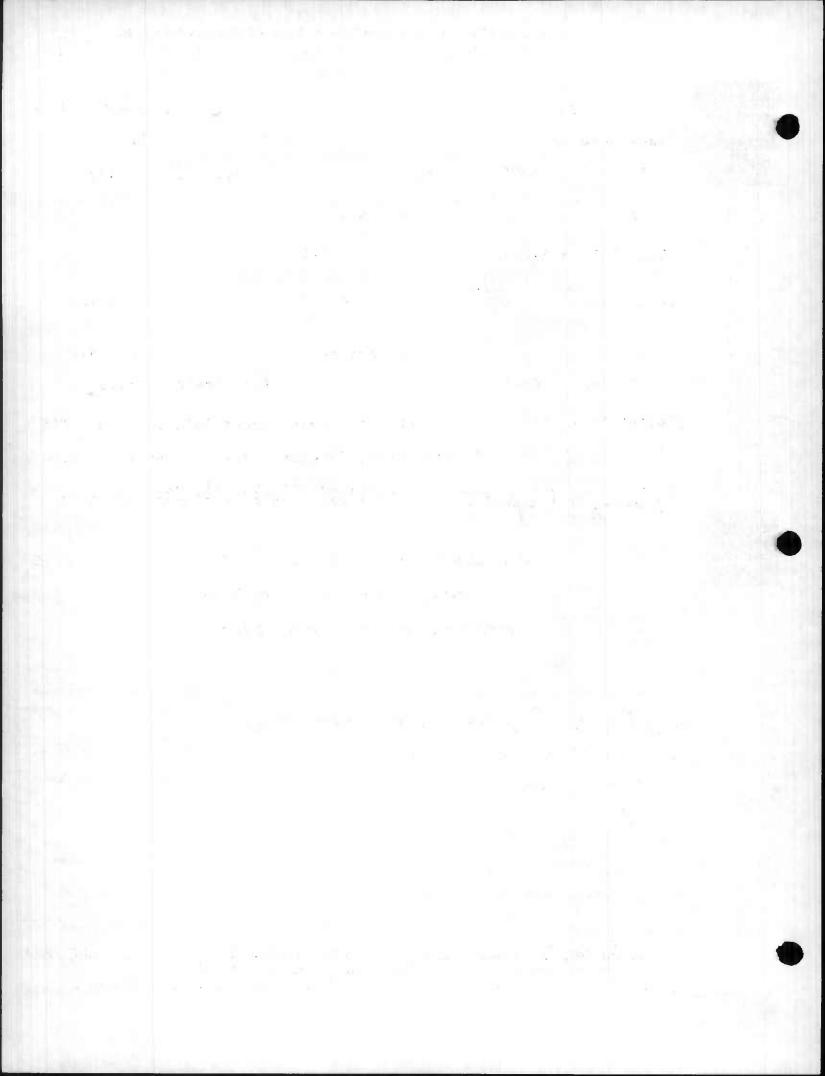


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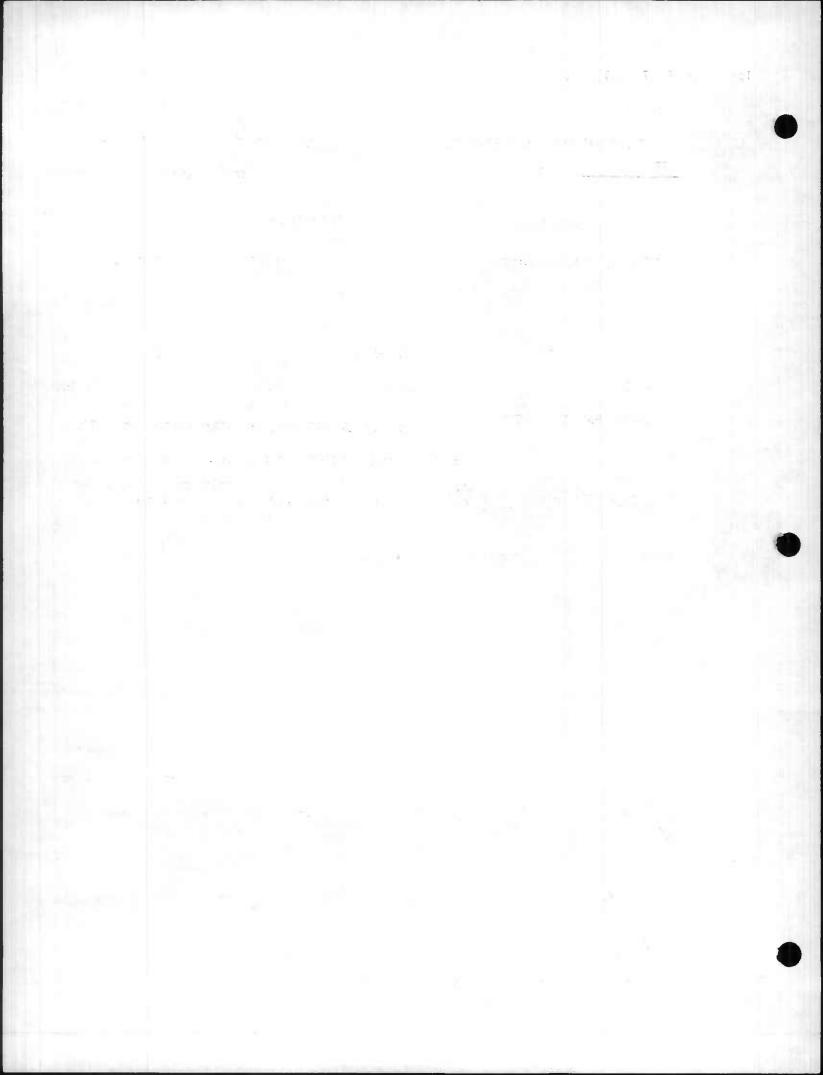
State of Maryland / Department of Health and Mental Hygiene 3 29 1 7

				Cer	tificate of	Death		Reg. No.		
Dhuai	alan	1. Decedent's Nama (First, Middle, Las	t)				2. Date of De			3. Time of Death
Physi /Med		Doris Bu	11				Janua	40	998 3	7:17 Pm
Exam		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Deat		of Death	
		Sinai Hospita				Baltim		N	1/A	
Funera Directo		213-10-3197	7. Aga (In	yrs. lest birthday) 78 Yrs.	Months Days		8. Date of Bir (Month, De	th ey, Year) 23,1919	9. Birthplace Country) Mary	
pus *_		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Loc	etion				104	Incide City Limite
Be-f sho	Director	Maryland N,			imore					1XDX es 2 □ No
ath with the 23s or 2 west be no	rai Dire	10e. Street and Number 3838 Roland	Avenue			211		10g. Citizen of V USA	Vhat Country	,
1215-0020 within 72 hours efter death with the Maryland ena. than "naturel", or items 23s or 28s-1 show its Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married X□XWidowed 4 □ Divorced	1 Never Married 2 Married 1 Yes Sive		/as Decedent of Yes, specify Cul ☐ Yes 2 ☐ No	Hispanic Origin? (5 ban, Maxican, Puer Specify:	k, White, etc.	1100.4		
and 21215-0020 be filed within 72 hours efter death with the Manylan tall tygiena. d other than "naturel", or items 23s or 28s-1 show event, it is Medical Examinet man be notified as	Completed	15. Decedent's Edi (Specify only highest gred Elementary/Secondary (0-12)	ent's Usual Occu ind of work done O NOT use retire Memake	ne during most of working ired)						
d High		17. Fathar's Nama (First, Middla, Last)		110	memake		me (First, Middle			ille
Maryland 2 42 should be filed h end Mental Hygi 7 is marked other traumatic event,	To Be	Vernon T.	Bull				da Vir		,	
Maryld d 2 should th end Mer 7 is merke traumatic	F	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing	Address (Stree	et end Number or R				
CHNL		Thomas Bull	(Son)							
Pages 1 gent of Hant: If Item		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 i 4 🗆 Donation 5 🗀 Other (Specify	Removal from State	 b. Placa of Dispos cemetary, crem 	ition (Neme of etory or other ple		Date	20c. Location -	City or Town,	State
Baltim permit. Pa Departmen Important: any injury	MARKE	21. Signature of Funeral Service Licens		22. B	Name and Addr	ess of Facility Henss F 11s Roa			-	
		Juney 17	arpenter	3	631 Fa	11s Roa	d Balt	imore,		
Physician /Medica Examine		23a Pan1 Enter the disease, or compensation, or heart failure. List only of immediate Causa (Final disease or condition resulting in death)							Or	nset and Death
Geath certificate be axecuted death certificate be axecuted e attending physician end of or use as the bunel-transit	n/Medical Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Urine Due to	o (or as a consequent of the consequence of the con	enca of):	info anti	biotion	2.5		
	Physician	Part II. Other significant conditions co	^					tobacco use cor		
COTGS, requires to been signs should be	Completed by	It was tino	f system; who to have	e dama	iged h	ertid	24a. Was perfo	an autopsy ormad?	availal	ble prior to ation of causa
The The ate h		and her	ens.				10	Yes 2 No		
VITAI stclan: Tr certificate irector, pa	Be	25. Was case referred to medical axaminer?	Hospital:		0		ath (Check only	one)		
ng Phy frer this	lon: To	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Year	2 ER/Outpatient 28b. Time of Injury	28c. Inju	ork?	Homa 5 ☐ Resi 28d. Describe	dence 6 Oth		
or Attending of Attending of Attending of Attended of	Certification	2 Accident Investigation 3 Suicida 6 Could not be 4 Homicide determined	M 1 C	Yes 2 No	28f. Location (City or To		er or Rurel Ro	Death A B. Birthplace (State or Foreit Country) Maryland 10d. Inside City Limit 11x Yes 2 N hat Country? American Indian, White, etc. White etc. White etc. White etc. White atc. White atc. White atc. White atc. White atc. White etc. White atc. White etc. White a		
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To the Within 2 To the	Mec	29b. Signatura and title of certifiar	and manner stated.		29c. Lican	se numbar		29d. Data signa	d (Month, Day	, Yaar)
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Registrar



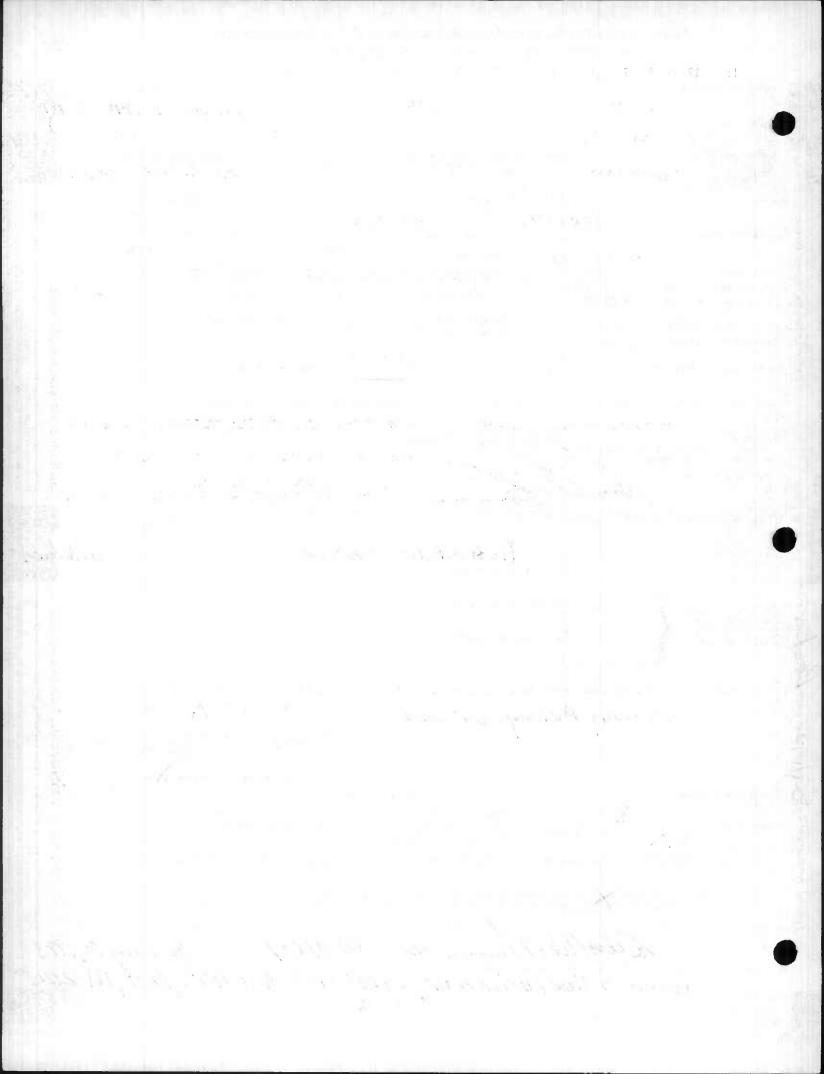
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sician	1	MAURICE	BASSAN					Month	Dey 3	Year 1990	1145	
edical miner		la. Facility Name (If not Institution, give					4b. City, Town, or	Location of Deal	th 4c. County	of Death	10 AY	
		FOREST HAVEN		HOME			CATONS	/TLLE				
eral		5. Sociel Security Number 6. S	Sex 7. Age	(In yrs. lest birtl	hday) If Und Month	lar 1 Yaar s Days	-	8. Date of Bi	rth		ce (Stete or For	
tor		557-09-6392	XXM 2□F	83 Y	rs.	Days	Tiodis Willia	MAY 7,	1914	Counti	"ISRAEL	
3	1	Jsual Residenca of Decedent 10a. State 10b. County		10c. City, Town	or Location					10.	d Japane City Lie	
by Funeral Director		Tob. Godiny		Too. Ony, Town	OI LOCATION	DI	encurr en			100	d. Inside City Lir	
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by Fur		1 ☐ Never Marriad XX Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent E Armed Forces? 12 Yes, 2 □ No If Yes, Give Year or Dates:	°wii		2XXNo	Specify:	to Rican, etc.)	Specif	ck, White, et		
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Be	מ	17. Fether's Neme (First, Middle, Last,)						, Maiden Sumen	ne)		
P		SAMUEL			BASSAN		ESTH				EMERS	
		19a. Informant's Neme/Reletionship (MARGARET BASSAN					end Number or Ru		er, City or Town,	Stete, Zip C	Code)	
	1	20e. Method of Disposition	, 11223	20b. Pleca of	7908_WI	NTERS	SET AVENU	JE PIKE	SVILLE,	A. 200	1208	
		Burial 2 Cremetion 3	Removal from State	cametery	, cremetory or	r othar piec						
۵	-	4 Donetion 5 Other (Special 21. Signature of Fyneral Service Licer		BETH 1			on of English	2/1/98 BALTIMORE, MD				
ouce		21. Signature of Funeral Service Licensee 22. Name end Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208										
	+	23a. Pert 1. Enter the disaase, or com shock, or heert feilure. List only	1. W	Wh							21208 Approximete	
al Examiner	- Valley	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Course (Disease or Injury	b. ————	Oue to (or as e co								
		Cause. Enter Underlying Cause (Disease or Injury that initiated events	un to for in a se	e consaquence of):								
iclan/Medical		resulting in death) Lest	nisaquerice oi	<i>J</i> -								
an.			d						1			
Sicia	1	Pert II. Other eignificant conditions of	ontributing to death but	not resulting In	tha undarlying	cause giv	en in Pert i.	23b. Did	tobecco use co	ntribute to t	he cause of de	
by Physician/M			eu C					10	Yes 2□ No	3 ☐ Proba	bly 45 Unki	
Completed t									en eutopsy ormed?	com	e eutopsy findin able prior to pletion of causa eeth?	
E								10	Yes 2 No	10	Yes 21 No	
Be		25. Wes case referred to medical examiner?					26. Place of Dec	eth (Check only	one)		•	
0	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatien		petient 3□ [4 Coursing F	lome 5 ☐ Res	idenca 6 □Oth	er (Specify)		
on:	1	27. Manner of Deeth 1 Naturel 5 □ Pending	28e. Dete of Injury (Month, Day		jury	28c. Injury Wor		28d. Describe	how injury occur	red		
at		2 Accident investigation 3 Suicide 6 Could not b			М		Yes 2 □ No		·			
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ertific	7	29a. Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, end due to the ceuse(s) end menner es steted.							ceuse(s) end me date end placa,	enner es stel	ted. he cause(s)	
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Medical Certific	3	(Check only 2 Medical Exam	and manner state		2	29c. License number				29d. Date signed (Month, Dey, Yeer)		
edicai	3	(Check only 2 Medicat Examone)	and manner state		2	-			29d. Date signe	d (Month, De	ey, Yeer)	
edicai	3	29b. Signature and title of cartifier	and manner state			-	e number		29d. Date signe	d (Month, De	ey, Yeer)	
edical	3	29b. Signature and title of cartifier 10. Name end eddress of person who	and manner state		Type, Print)	D4-			29d. Date signe	d (Month, Di	ey, Yeer)	



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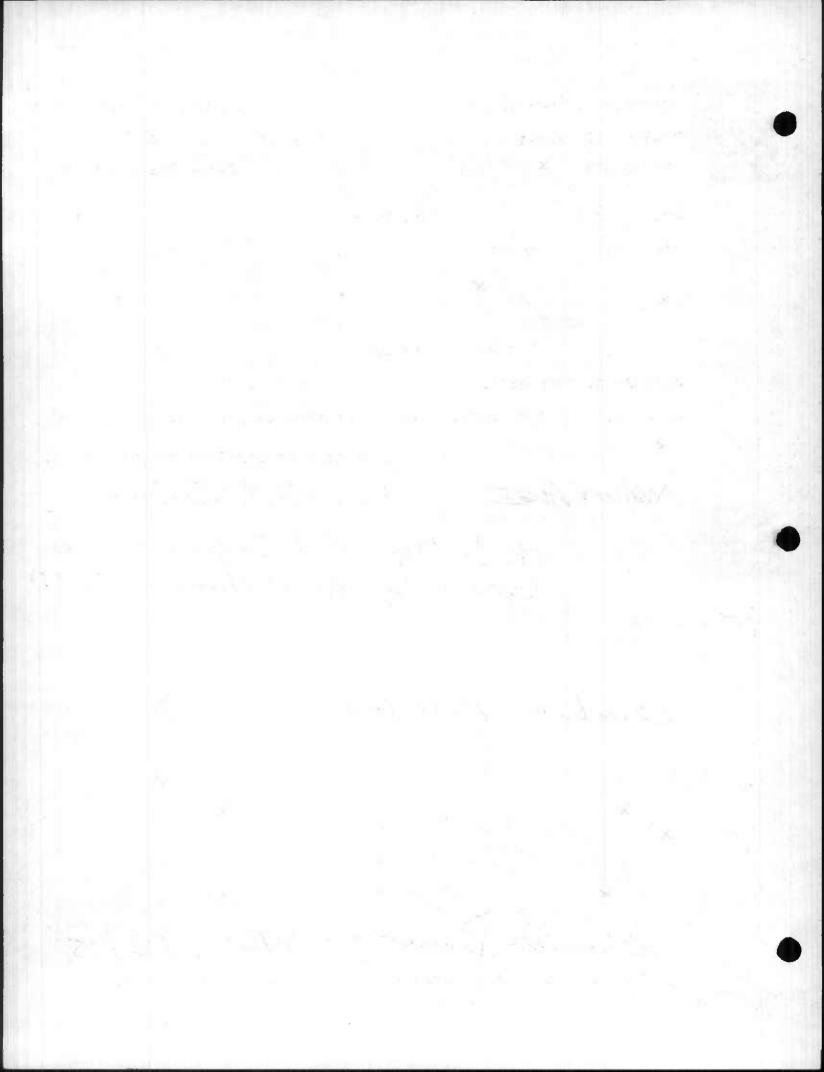
Certificate of Death Item #17 per FH G756 2/3/98 EW 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 9/1 Month Des **Physician** BECKER 29 1998 an wary /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE LEVINDALE N/A 5. Social Security Number If Under 1 Yeer If Under 24 Hrs.
Months Deys Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2/2) 82 Director OCT. 8, 1915 213-48-1428 MARYLAND Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. fnside City Limits Show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director 1 ☐ Yes 21/21/10 BALTIMORE BALTIMORE 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zin Code 21208 USA 6 MONTAIGNE CT APT. 3B death 1 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Reca - American Indien, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ NY altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XN Specify: WHITE Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondery (0-12) Coilege (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumame) Pages 1 and 2 should be filment of Health and Mental Hant: If item 27 is marked other Be GABELL 0 SAMUEL REIFF LEAH TAYLOR 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 MONTAIGNE CT; APT.3B; BALTIMORE, MD 21208 BENJAMIN BECKER / HUSBAND other 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 □ Rurial 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) 5 permit. Page Department of Important: If any Injury or once. OFFIL YAKOV BETH ISRAEL FEB.1, 1998 BALTIMORE, MD 21. Signature of Funeral Service Linear 22. Neme end Address of Fecility
SOL LEVINSON & BROS, INC. 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. Approximete Intervel Between Onset end Deeth **Physiclan** /Medical Immediete Ceuse (Finei 11 Knows diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examine Sequentially list conditions, if eny, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): physician the buria Physician/Medical Due to (or es e consequence of): 88 attending p ed by the detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 XY08 2 No 3 Probably 4 Unknown isease ð 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed certificate has 1 🗆 Yes 25. Wes case referred to medical exeminer? Be 26. Pleca of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 2 ER/Outpatient 3 DOA mis 27. Menner of De 28d. Describe how injury occurred 28c. Injury et Work? Certification: Division 1 Neturel
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 100 ictor: 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steled.

Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner stated. Medical (Check only one) 29b. Signature and title of certific 29c. License number 29d. Dete signed (Month, Dev. Year, 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 2434 W. Belvedere Ave THE non TD 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 2 9 2 0 State of Maryland / Department of Health and Mental Hygiene

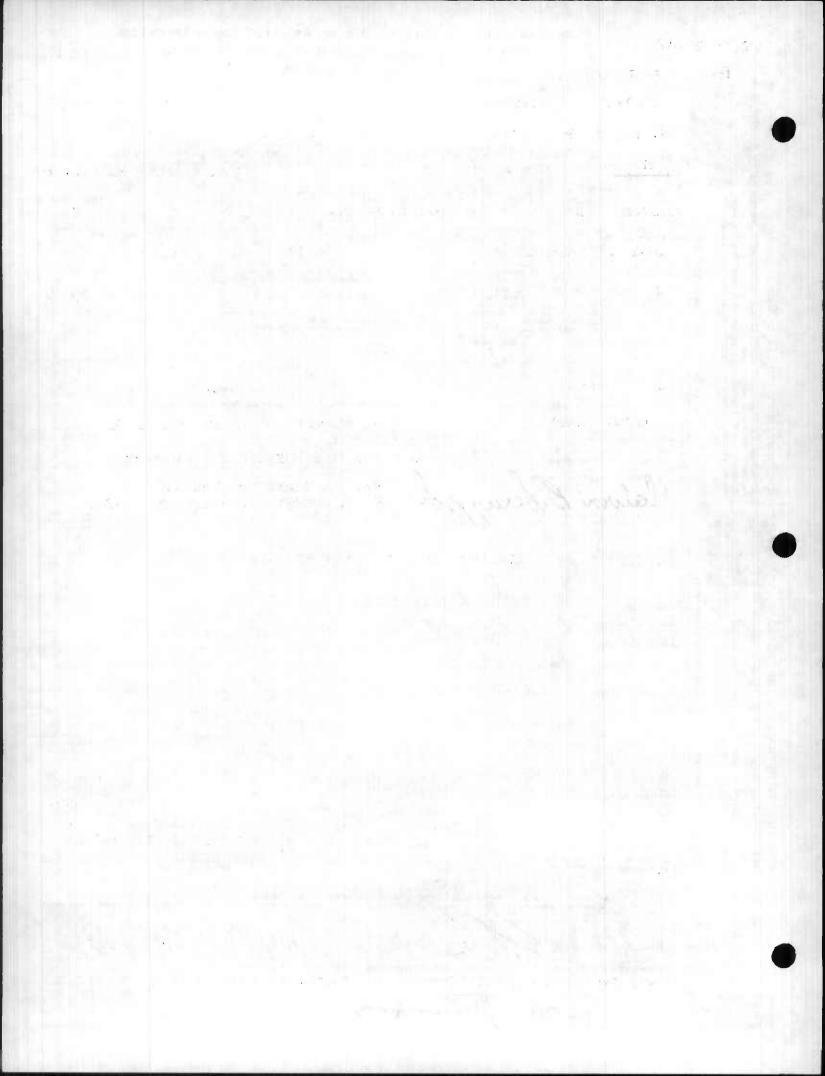
						Ce	rtificate	of	Death		Reg. No.		
Physician		Decedent's Neme (First, Middle, Last)								2. Dete of Deeth 3. Time of De Month Day Yeer			
/Medical	ı I.	EVERETT L. BUCKMASTER							JANUA	RY 29,	1998	11:00AM	
Examiner		le. Fecility Neme (If not institu ROLAND PARK			nber)			_	4b. City, Town, or BALTIMO	RE	N/A	y of Deeth	
Funeral Director		5. Sociel Security Number 217-38-3202	6. S	ex M 2□ F	7. Age (In yrs 94	. lest birthday) Yrs.	If Under 1 Months	Year Days			th y, Year -1903	9. Birthpla Count MARY	ace (State or Foreign in) LAND
*	- 1	Usuel Residence of Decedent 10a. Stete 10b. Cou	ntv		10c C	ity, Town or Lo	nation					140	
sidet		MD. N/A	· · · y		100.0							10	od. Inside City Limits 1 Yes 2 No
or 28a-f sl be notified Director	3	10e. Street end Number				BALTI		Sa dili			40 00		
0 8 0	5	830 WEST 4	ОТН	STREE	T		10f. Zip 0	12	11		10g. Citizen ot USA	Whet Count	ry?
Examiner must	2	11. Maritel Status 1 ☐ Never Married 2 ☐ M 3 ▼ Widowed 4 ☐ Divord		12. Was Dece Armed For 1 Tyes If Yes, Give Year or Da	ces? 2 No		Wes Decede It Yes, specif 1 ☐ Yes 2		HispenIc Origin? (S en, Mexican, Puert Specify:	pecify Yes or No o Ricen, etc.)	14. Ra Ble Specifi	ce - Americe ck, White, e	etc.
tal Hygiene. d other than "natur event, tra Medical Be Completed		15. Deced (Specify only hig	nest gre	de completed)		16a. Dece (Give life.	16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)					Business/Indu	ustry
thar than		Elementary/Secondary (0-12)	College (1-4YRS			ORNEY		-/		LAW		
othe othe		17. Fether's Name (First, Midd	e, Last)						18. Mother's Nar	ne (First, Middle,		me)	
Mental arked o atic eve								ETTA E	E. WARD				
PEL		19a. Intorment's Neme/Relation				19b. Mailir	ng Address (Street	end Number or Ru		er. City or Town	. Stete. Zip (Code)
		JAMES D. ST	ONE	(ATTOR	NEY)	1000000			UEHANNA				21204.
It He He He	2	20e. Method of Disposition			20b.	Plece of Dispo cemetery, crea	sition (Neme	of of		Dete	20c. Location	-	
6 # >		4 Donation 5 Other				UID R	IDGE	CE	METERYO	2/02/9	8 PIKE	SVILI	LE, MD.
Department of Important: If any Injury or once.		21. Signeture of Funeral Servi	e Licen	212	,		HENRY	W	ess of Fecility BRK RD.	NS & S	ONS CO		
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s been s 2 should pleted	-									24a. Wes perfo	en eutopsy med?	evai	re eutopsy tindings ileble prior to apletion of ceuse eeth?
page 2										101	res 200	10	Yes 2□ No
certificate rector, pag		25. Wes case reterred to medi exeminer?	al						26. Place of Dec	oth (Check only o	ne)		
To I		1 Yes 2 No		Hospital: 1 In	patient 2	ER/Outpetier	t 3 DOA	Oth	ner: 4 Nursing H	lome 5 Resid	dence 6 Ott	ner (Specify))
		E - Modidoni	tlgation		I Injury , Day Yeer)	28b. Time of Injury	M 280	v. Injui Wor 1 □	ry et rk? ∣Yes 2 ☐ No	28d. Describe I	now injury occur	rred	
rs effer death. al Director: Affer t led in by the funera Certification:		3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined	286. Piece o	of Injury - At h g, etc. (Speci	ome, ferm, str fy)	eet, factory,	office		28t. Location (S City or Tov		ber or Rurel	Route Number,
in 24 hour he Funer pletely fill edical		29a. Certifier (Check only one) Certification (Check only one)	ring Phy al Exem	ysician: To the b liner: On the bas and manny	sls ot exemine	owledge, death etion end/or inv	occurred et restigetion, in	the tir	me, date end place opinion, death occu	, end due to the rred et the time,	ceuse(s) end m date end plece,	enner es ste end due to l	rted. the ceuse(s)
To the comp		29b. Signature end title of certi	ier	0	5	2/	29c. I	Licens	se number	15	29d. Date ligne	ed (Month, D	Ney, Yeer)
	3	0. Neme end eddress ot person	n who e	completed cause	of death (Ite	m 23e) (Tvne	Print)	C) 1.10	30	1/3	0/	70
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State	3	11. Dete tiled (Month, Day, Yea	r)	Letia &	strer's Sign	Aunda 12							



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State of Maryland / Department of Health and Mental Hygiene 8 929

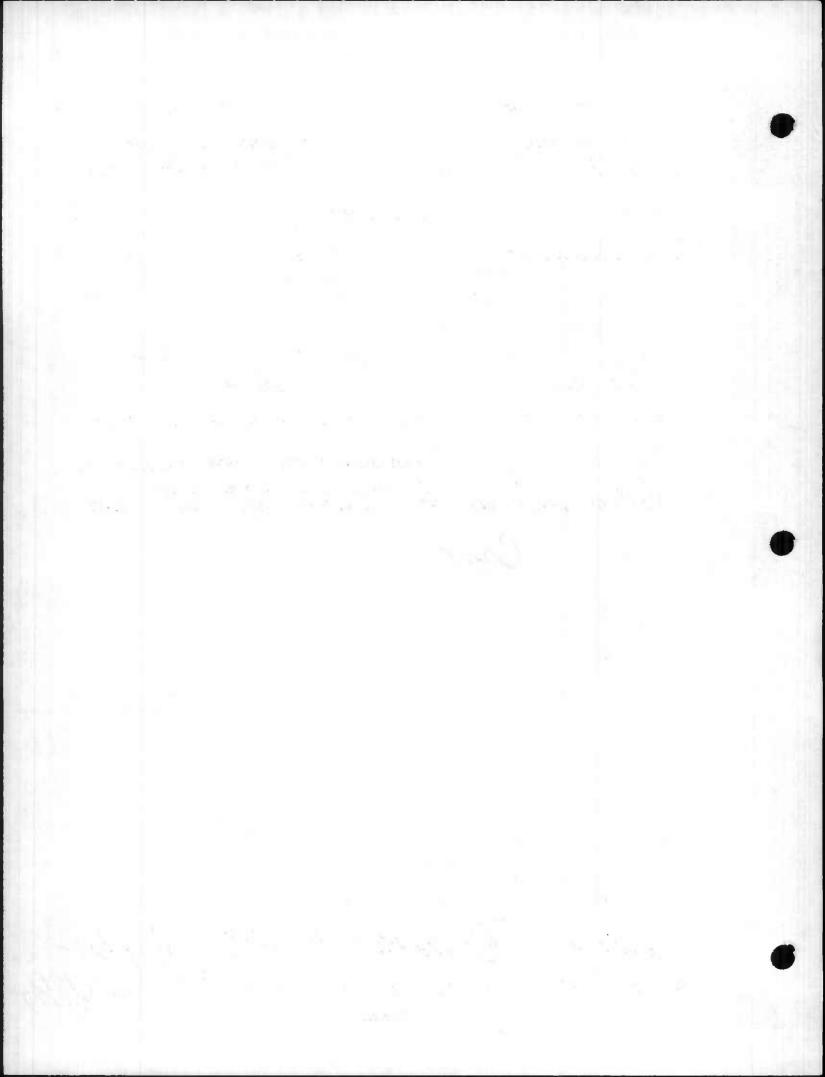
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Physician		BURTON					Month JANUAR	Day	Yaar	
/Medical Examiner	4a Facility Nama (If not institution, give 700 BLK. FILLMORE	street and number) E STREET				lb. City, Town, or BALTIMOR	Location of Death	-	of Death	
Funeral Director	5. Social Security Number 216-96-4306 216-200 Usual Rasidance of Dacedant	7. Aga (In yr	s. last birthda Yrs.	y) If Und Month	ar 1 Yaar B Days	If Undar 24 Hrs Hours Min		th y, Year) 1979	9. Birthplaca (Stata or Foraign Country) PENNSYLVANIA	
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Urs at	3 ☐ Widowed 4 ☐ Divorced	12. Was Dacedant Evar in Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:	U,S. 13	S. 13. Was Decedant of Hispanic Origin? (Specify Yas or No- if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Yas 2 No Specify: 14. Race - Amarican Indian, Black, Whita, atc. Specify: NEGRO						
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should be nd Mentel marked our umatic even	JERRY BURTON CHER							T		
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or Heal	CHERAND MONROE 20a. Mathod of Disposition 1 Burial 2 Cramation 3	Ramovai from Stata	. Place of Dis cematary, cr	amatory o	eme of othar pla	>e)	LTIMORE, Date	20c. Location	1218 - City or Town, Stata	
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on of \ ding Physic th. After this c funeral dire		28a. Data of injury (Month, Day Year)	28b. Tima Injury	of	28c. Injui Wor		28d. Dascribe	how injury occu	rred AUTO	
Division (To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funer. Medical Certification:	3 ☐ Suicida 6 ☐ Could not be detarmined	1-28-98 28a. Piace of Injury - At building, atc. (Spe UNKIN	cify)	straat, fact		×		Street and Num wn, Stata) UNKNOV	ber or Rural Routa Number,	
ne Hospital n 24 hours ne Funeral pletaly filled		rsician: To the bast of my k Inar: On tha basis of exami	nowledge, de	ath occurre	d at tha tir	na, data and place pinton, death occ	e, and dua to the curred et the time,	cause(s) end m dete and place,	ennar as stated. and dua to tha ceuse(s)	
To the Hospital within 24 hours a To the Funeral I completaly filled Medical Ce		and manner stated.		2	9c. Licans				ad (Month, Day, Year)	
5	30. Nama and addrass of person who of				O.C.		Maryland		29, 1998	
State	David Fowler, M. 31. Data filad (Month, Day, Year)	32. Paringarage	min St.	LCCL,	DOJ. (INIC, I	жт. у така	2120 J.		



State of Maryland / Department of Health and Mental Hygiene of Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** 28,1998 JAN. HENRY BUTLER 5 AM /Medical 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 2326 E. OLIVER STREET BALTIMORE CITY 5. Social Security Number If Under 1 Year if Under 24 Hrs. Hours Min. 8. Date of Birth NOV. 7,1920 7. Age (In yrs. lest birthday) 9. Birthpiece (Steta or Foreign **Funeral** Days 1 M 2 F 77 VIRGINIA 218-92-4556 Yrs. **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23s or 28s-f show Iry or other traumstic event, the Medical Examiner main be in citied as 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND N/A BALTIMORE CITY 1 XYes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 2326 E. OLIVER STREET 21213 U.S.A. Funerai 12. Was Dacedent Evar in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Navar Married 2 Married 1 Yas 2 No If Yes, Give Yeer or Detas: Baltimore, Maryland 21215-0020 1□ Yas 2 No **NEGRO** p 3 Widowed 4 Divorced Completed 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completad) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) UNKNOWN UNKNOWN N/A UNKNOWN 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Meiden Sumeme) Be EMANUEL BUTLER HENRIETTA P 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MINNIE PIGATT / NIECE E. OLIVER STREET BALTO, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Department of important: If It any injury or one 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Dogetion 5 ☐ Other (Specify) ZION CEMETERY FEB. 3, 1998 Baltimore, Md. CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each eath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Physiclan Immediete Cause (Finel disaese or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leeding to Immadiate cause. Entar Underlying Ceuse (Disease or injury thet initieted events rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai usa signed by the a Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown þ 24b. Were eutopsy findings availabla prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed peen has page 2 cartificata 1 Yee 2 1 No 1 □ Yas 2 □ No Hospital or Attending Physician:
 124 hours after death.
 Funeral Director: After this carific. funaral director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not ba determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, streat, factory, offica building, etc. (Specify) 2 4 Homlcide filled in 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) end menner es stated. Medical completaly 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and manner steted. To the I within 2 my 29d. Deta signed (Month, Pey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) IXON 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State 3 his Davidson

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** VAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner 8. Date of If Undar 1 Yaar 5. Social Security Number 6. Sax 7. Aga (In yrs. last bighday) 9. Birthplace (State or Foreign **Funeral** 113M 20 F Months Days Min Yrs. **Director** sidence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23s or 28s-f show treumatic event, the Modical Examiner must be notified at 19765 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 2 should be filed within 72 hours after n and Mantal Hygiene. Yes 2 7 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Nama (First, Middle, Maiden Sumame) To Be 17. Father's Na 1CHARDSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type permit. Pages 1 end 2 sh Department of Health and Important: If Itam 27 is m any Injury or other treum once. 20b. Plac Date Method of Disposition Pages 1 1 Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Coneral Service Licenses lications that caused the death. Do not enter the mode Approximate Interval Between Onset and Death , or complications that caused in List only one cause on each line **Physician** Prostate Cancer /Medical Immediate Cause (Final disease or condition resulting in death) eer 5 **Examiner** Due to (or as a consequence of) Examiner hind Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): the attanding physical Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Part i. dateched s been signed by the should be datech 1 Yes 2 No 3 ☐ Probabiy 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy Completed After this certificate has page 2 2/2 No 1 Yas 2 No funaral director, 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Stella Mavis Be Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) OSPICO 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of injury 28c. Injury at Work? 1 Netural ours after dean 5 Pending investigation 2 No 1 Yes 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - Al home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Hospital To the Hospital within 24 hours To the Funeral 29a. Certifier To the cause(s) end memora as stated. edical 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certify 29c. License number

s of person who completed cause of death (Item 23e) (Type, Print)

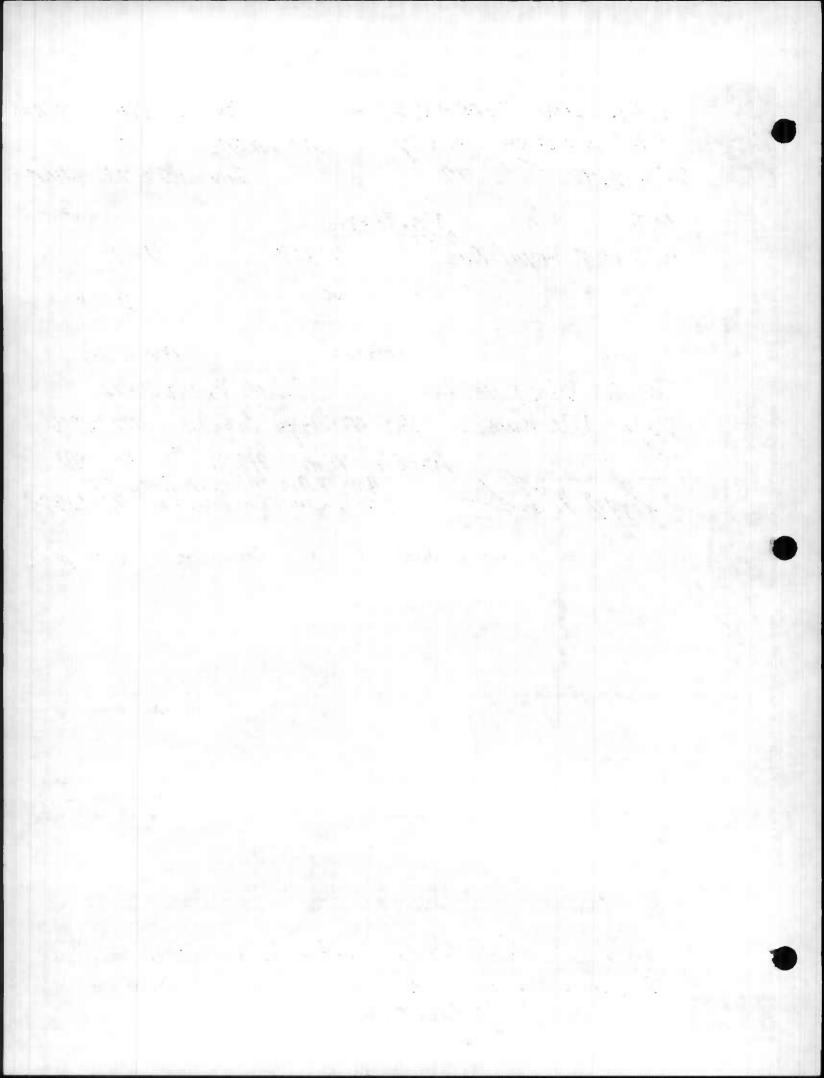
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31. Data filed (Month, Day, Year)

St Paul Please

MD 21292

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer February 1, 1998
Pation of Deeth | 4c. County of Deeth 6:03 A.M. BASEMAN 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Deeth Franklin Square Hospital Center
5. Social Sacurity Number 6. Sex 7. Aga (In yrs. les Rosedale r If Undar 24 Hrs. Baltimore If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) NOV 22, 1912 7. Aga (In yrs. lest birthday) Birthplaca (State or Foreign Country) Months Deys Hours 1₩ 2□ F 85 Yrs 217-03-2364 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Harford Fallston 1 ☐ Yas 2 ☑ No 10f. Zip Code 10a. Citizen of Whet Country? 10e. Street and Number 1718 Parkvue Road 21047 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Marriad 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Building Industry Carpenter 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumema) George B. Baseman Ruby A. Merryman 19a. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) Clarence Baseman / brother 1718 Parkvue Road Fallston MAryland 21047 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Steta 1 ☐ Burial 2 € Cremetion 3 ☐ Removel from Steta 4 ☐ Donetion 5 ☐ Other (Specify) 2/3/98 Metro Crematory Inc. Baltimore 21. Signatura of Funeral Service Licensae 22. Name end Address of Fecility Connelly Funeral Home of Essex onn 300 Mace AVe. Baltimore Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth Immediete Ceuse (Final 1 Hour diseese or condition resulting in death) Respiratory Arrest Due to (or es e consequence of) Congestive Heart Failure Due to (or es e consequence of) Acute Myo Cardial Infarction Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 24e. Wes en eutopsy Chronic Obstructive Pulmonary Disease 1 Yes 2 No 1 Tyes 2 No. 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Physician /Medical Examiner

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i or Attending efter death. Director: Aft

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Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

the Maryland

death

filed within 72 hours after

permit. Pages 1 end 2 should be filed within 7. Depertment of Health and Mental Hyglane. Important: if Item 27 is marked other than "na any injury or other traumatic event, the Medic page.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Undarlying Ceuse (Diseese or Injury that initiated events rasulting in death) Lest

Digoxin Toxicity

Chronical Depression

25. Wes cese referred to medical

1 Yes 2 No

27. Manner of Deeth 1 Neturel 5 Panding investigation 2 Accident 3 Sulcide 6 Could not be

4 - Homicide 29a. Certifier

28e. Dete of Injury (Month, Day Year)

28e. Plece of Injury · At home, ferm, street, factory, office building, atc. (Specify)

28b. Time of 28c. Injury et Work? Injury 1 Tes 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner steted.

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29b. Signature and title of certifier

29c. Licansa number H35593

29d. Data signed (Month, Day, Year) February 1, 1998

(Check only one)

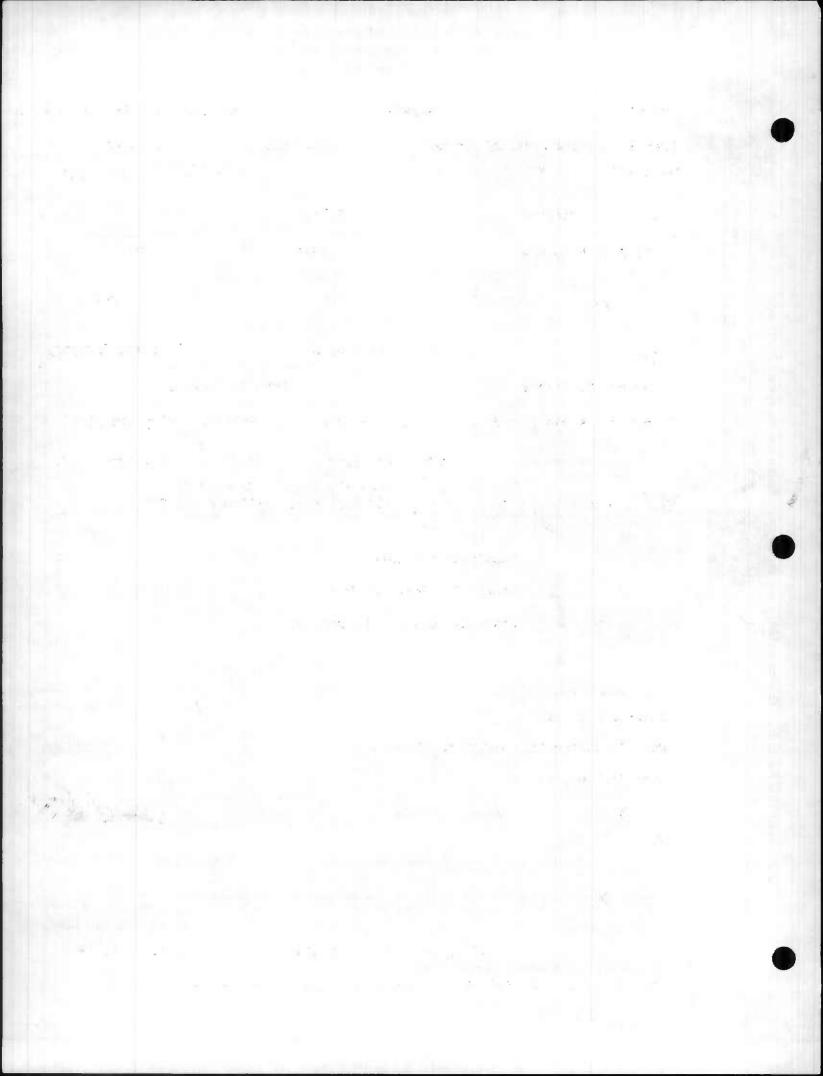
30. Neme and eddress of person who completed cepse of deeth (Item 23e) (Type, Print)

John Loh M.D. 9000 Franklin Square Drive

Baltimore, MD 21237

State Registrar

32. Hegistrer's Signature and all 31. Dete filed (Month, Day, Year) 0 3 1998



sician	1. Decedent's Neme (First	t, Middle, Las	st)			rtificate of		2. Dete of De	Reg. No.	3	3. Time of Death
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edical miner	4a. Facility Name (If not in	nstitution, givi	a street end nu	ımber)			4b. City, Town, o	r Location of Deat			12 13 1711
	Sinai Hos	spital	of Bo	altimo	ore		Baltimo	ore City	N/Z	A	
ral tor	5. Social Security Number 212-10-6024	6. S			rs. last birthday) Yrs.	If Undar 1 Yaa Months Days			th by, Year) 1904		a (Steta or Foreign) 1and
Be Completed by Funeral Director	Usuel Residence of Deced	dent County		100	Oh. Taua asla						
to		altimo	re	100.	City, Town or Lo						Insida City Limits 1 ☐ Yas 2 ☐ No
Director	10e. Street end Number					10f. Zip Code			10g. Citizen of	What Country	7
	7 Sudbroo	k Lane				21208			U.S.A.		
by Funeral	3 ☐ Widowed 4 ☐ Divorced		12. Was Dec Armed Fo 1 Tas It Yes, Gi Yaar or D	orcas? 2000No ive	U.S. 13. Was Decedant of Hispanic Origin? (Specify Yas or No- It Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece- Biack, 1 1☐ Yas 21XNo. Specify:				ce - American ck, Whita, etc.		
Be Completed	15. Do	ecedent's Ed	lucation da completed)		18e. Deced	dent's Usuei Occu	petion	orkina	16b. Kind of B		
npie	Elementery/Secondery	1	Coilege (during most of w ed)	Orking			
S	6 yrs.	90/4/4/- 1 41			Worke	er	1 40 14 11 11	4551 4 4 41 4 41	Hat Fa		
	17. Fethar's Nama (First,) John Pe	middie, Lasi) ter	Beck				1	eme (First, Middle		ne)	
10	19e. Intorment's Neme/Re				19b. Mailir	ng Address (Street	Mary	M . Rural Route Numb	Cravo er. City or Town.	State Zin Co	ode)
	Fred Dibart			rator		dbrook L		kesville			
	20a. Mathod of Disposition	n		20t	Place of Dispo			Data	20c. Location -		
	1 ☐ Buriel 2 ☐ Cren 4 ☐ Donetion 5 ☐ O			Stata		ark Ceme		26/98	Baltimo	re, Ma	ryland
	21. Signature of Funeral	Benyice Lipen	500	11/	22	2. Nama and Addi	ess of Fecility		105	0 York	Pond
	1/2	10	1/0	1/	Rı	ick Towe	on Funer:	al Home,			
n il r	23a. Pert1. Enter tha dise shock, or heart feilur Immediate Cause (Finel disease or condition resulting in deeth)	re. List only	a.		Str	oke	ing, such as cardi	ac or respiratory e	rrest,	Or	pproximete terval Between nset end Deeth
ē				Due						1	
1 -=	1770	-			o (or es e consec	quence of):					
Examiner	Sequentially list condition if eny, laading to immedia cause. Enter Underlying	s, ote	b. ———	Due to	o (or es a consec						
edical	Sequentially list conditions if eny, leading to immedia cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last	s.	b. ————————————————————————————————————			juence of):					
edical	cause, Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last	1	b. ————————————————————————————————————	Dua to	o (or es a conseq	uence of):					
Physician/Medical	Cause, Enter Underlying Ceuse (Disease or Injury that initiated events	1	b. — C	Dua to	o (or es a conseq	uence of):	íven In Pert I.				14
by Physician/Medical	cause, Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last	1	b. ————————————————————————————————————	Dua to	o (or es a conseq	uence of):	iven In Pert I.	1 🗆		3 Probeb	autopsy tindings ibla prior to letion of cause
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edical Certification: To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Pert II. Other eignificant c 25. Was case reterred to rexeminer? 1 Yes 22 No 27. Manner of Death 1 Natural 5 1 2 Accident 3 Suicide 6 4 Homicide 29a. Certifiar 12 C.	medical Pending Investigation Could not be determined	Hospitel: 1 28e, Date (Mon 28e, Plece buildi	eath but not of injury th, Dey Year, and injury - Aing, etc. (Spe	o (or as a consequence of consequenc	uence of): uence of): uence of): nderlying cause g 28c. Inju W M 1D eet, fectory, office	26. Piece of Dither: 4 Nursing at oh? Yes 2 No	24e. Wes perfe	Yes 2 No an autopsyormed? Yas 2 No one) dence 8 Oth how injury occur Street end Numb wn, Stete)	3 Probeb 24b. Were availed completed and a steel availed completed and a steel availed completed and a steel and	autopsy findings bla prior to letion of cause ath? as 22 No
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The state of the s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ht's Name (First-Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 27, 1998 4c. County of Deeth ATAUN DI /Medical 4e. Fecility Neme (If not institution, give stre 4b. City. Town, or Location of Deeth **Examiner** Th West Candal/stown Ba Himore Hay 5. Social Security Number If Under 1 Year if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Y May 29, 6 Sax 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** Deys 1 M 2 F 220-98-9578 Yrs Director lay Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Director Ma law 10e. Street end Numb 10f. Zip Code 10g. Citizen of Whet Country? ŏ ·S.A or items 23a Road 21244 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Maritel Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2D No Specify. Indian þ 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: If Item 27 is merked other than Elementary/Secondary (0-12) College (1-4or 5+) ourm arm Work anknown Unknown 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Muhammag Bano 10 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Jon Wood lawn, nd 2/244 -011 das haudhry 20b. Place of Disposition (Name of cemetery, cremetory or other ple . Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 Removal from State 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee 21215 40, Wabast 4300 Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximete Intervel Betwee Onset and De Physician /Medicai Immediate Cause (Final disease or condition resulting in death) esdidy rknow Examiner Due to (or es e consequence of) Examiner buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest and Due to (or es e consequence of): The law requires that the death certificete be execu ettending physician for use as the burie P.O. Box 68760, Physician/Medical the Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of ceuse of deeth? page 2 1 Yes 2 0100 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 20 No 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

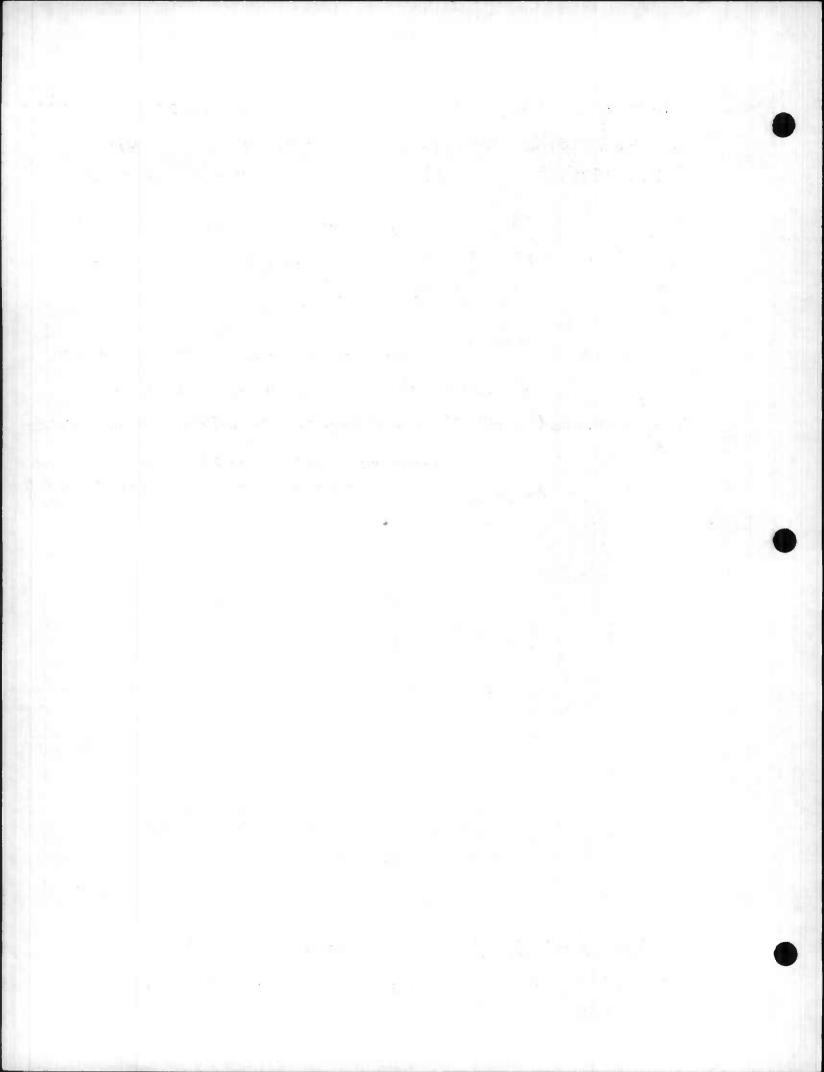
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) Medical 29a. Certifier 29b. Signature and tilli 29d. Date signed (Month, Dey, Yeer) 29c. License number 30. Name end address of person who complete Malone, of deeth (Item 23e) (Type, Print)

State Registrar 31. Dete filed (Month, Dey, Year)
FEB 0 3 1998

2 Registrar's Signeture

No. of Letters of the most of the

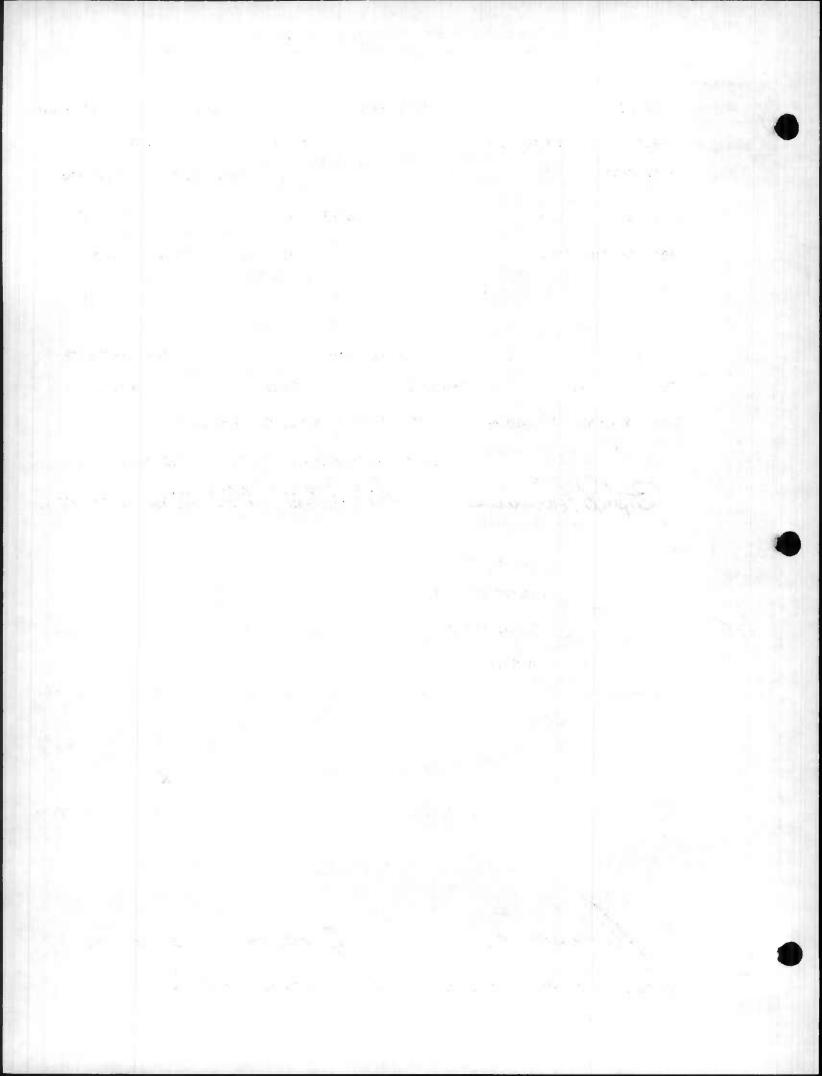
					nai yiai	Certific			, ,	eg. No.		
	Physic	ian	Decedent's Name (First, Middle, Li	CAWTHO!				2. Date of Dea Month	th Day	Year	3. Time of Death	
	/Medi		FERRON A.			JANUAN		494	11-m			
	Exami		4a. Facility Name (If not institution, gh	ve street end numbe	or)			4b. City, Town, or I	ocation of Death	4c. County	of Death	
			CHURCH HOI	me Ho	SPI	TAL		BALTI	HORE		V/A	
	Funeral		5. Social Security Number 6.	Sex 7. /	Age (In yrs.	last birthday) If Ur Mont	nder 1 Year ths Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	niace (State or Foreign
-	Director		226-27-55 18	1X M 2□ F		73 Yrs.	Days	Tiours Will.	SEPT, IT	1.1924	VIR	GINIA
	p .		Usual Residence of Decedent 10a. State 10b. County		10- 01							
	with the Merylend a or 28a-f show be notified at			/ .	10c. Ci	ty, Town or Location	~		d		1	Od. Inside City Limits
	M 98	Director	THE THE PARTY OF T	N/A			BA	-LTIHORI	= CITY			1 Yes 2 □ No
	with the a or 2	Dire	10e. Street end Number			10f.	Zip Code		/	0g. Citizen of V	Vhat Cour	itry?
		je	918 N. CAS	STLE S	TREE			2120	5	- (151	7,
	72 hours after death natural", or items 23 dicel Examiner must	Funeral	11. Meritel Status	12. Was Deceder Armed Forces	nt Ever in L	J.S. 13. Was De	ecedent of H	lispanic Origin? (S en, Mexican, Puert	pecify Yes or No-		e - Americ k, White,	an indlen,
0	or it		1 Never Married 2 ☐ Married	1 Yes 2	No 6 - 8	2-43 1 1 Ya	s 2 2 No	Specify:				
9	ral,	d by	3 ☐ Widowed 4 ☐ Divorced	Yeer or Detes	3-20	3-46		opeony.		Specify	BL	ACK
21215-0020	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Decedent's L	lent's Usual Occupation kind of work done during most of working O NOT use retired)					
2	within ene.	npi	Elementary/Secondary (0-12)	Coilege (1-4o	r 5+)			~	0			
	77 00 10	CO	11+HGRADE			STO	CK	CLERK		PANTA		PRIDE
Pu	0 = 0 5	Be	17. Father's Name (First, Middle, Last	"				18. Mother's Nan	ne (First, Middle,	Ma <i>iden S</i> umam	e)/	1
Na Na	should be nd Mental marked o	10	KOY	CAU	THO	ORN		RUTH	WILL	EK	EYT	ON
Maryland	d 2 shoth and the and traum		19a. informant's Name/Relationship		1 1 41	19b. Meiling Add	ress (Street	and Number or Ru	ral Route Number	, City or Town,	State, Zip	Code)
777	1 and Health em 27 rther tr		MARY EDMONDS	COMMO				TLE STA				21205
<u>S</u>	0 - 5 0		20a. Method of Disposition	-		Piace of Disposition (cometery, cremetory	(Name of or other plea	ce)	Dete	20c. Location -	City or To	wn, State
Ĕ	Pege net c iny or		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		9	+PRISON		3	2-52-98	OWING	S MII	LS, MD,
Baltimore,	permit. Pe Departmer Important: any injury		21. Signature of Funeral Service Lice	nsee		22. Name	e end Addre	ss of Fecility	1 -		/	lome, P. A.
Ö	Depa Impo any l		21	ARI	2:7	JOSE	=PH	H. BROW	NOK. I	-UNER	ALI	OME, P. H.
			23a Part 1 Enter the disease or com	pilostions that colo	ed the dear	th Do not only the	ON, I	FULTON.	AVE. BI	+LTIHOR	E, MI	1,21217
	Discourse of the second		23a. Pert1. Enter the diseese, or com shock, or heart failure. List only	one cause on each	line.	ui. Do not enter the r	node or dyn	ng, such as cardiec	or respiratory arr	951,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Finel									
	Examiner		disease or condition resulting in death)	a. CONG	ESTI	VE HELD	XT P	ALLINE				1 LEAN
		L O		TART		or es a consequence						14
	pet lisit	Examiner		b. MITTER		LENON		MOU US	SCHUM	a DIS	RASU	TEGRES
	be exacuted ician end buriel-transit	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			or es e consequence	of):				1	
09	be ed loian burle		Cause (Disease or Injury	· RENI	n	Forum	2					2 WEEKS
68760,	icete be exe physician e s the buriel-	edicai	that initiated events resulting in death) Last		Due to (d	or as e consequence	of):				i	
				d							i	
Вох	ettending for use a	ian									i	
	e de	sic	Part ii. Other significant conditions of	contributing to death	but not res	suiting in the underlying	ng cause giv	en in Part I.	23b. Dld to	bacco uae cor	ntribute to	the cause of death?
P.0	at th	P	CUM						1XY	es 2 No	3 Prol	bably 4 Unknown
	requires that the death certi een signed by the ettending hould be deteched for use a	Completed by Physician/M	001.8									
D	been s	Pe							24a. Was a	n autopsy med?	avi	ere eutopsy findings allable prior to
S	> 00	pie									of	mpletion of cause death?
œ	The la	mo:							1 🗆 Y	s 22No	10	Yes 2□No
ta	ician: The lav certificate hes rector, page 2	Be C	25. Was case referred to medical					28. Place of Dea	th (Check only or	ne)		
>	ysician: is certifica director,	ToB	examiner? 1 ☐ Yes 2 ZNo	Hospital:	tient 2	ER/Outpatient 3	DOA Oth	or	ome 5 Resid		er (Specifi	v)
Division of Vital Records,	문 부 등		27. Manner of Death	28a. Date of In (Month, D		28b. Time of	28c. injur Wor		28d. Deacribe h			
on	leath. or: After the funer	atio	1 Natural 5 Pending 2 Accident investigatio		ay Year)	injury M		Yes 2 □ No				
18	after death Director: A in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not b	289. Place of I	njury - At h	ome, farm, street, fac	ctory, office		28f. Location (S	treet and Numb	er or Rura	I Route Number,
Š	after of Dinect	T o	4 Homicide determined	building, e	etc. (Specia	fy)	,,		City or Tow	n, State)		
		-	29a. Certifier 1 Certifying Pt	weiclan: To the bes	t of my kno	owiedge, death occur	red at the tir	me date and place	and due to the o	aueo(e) and me	nnor se el	tetod
,	皇人是	edice	(Check only 2 Medical Examone)	niner: On the basis and menner:	of examina	ation and/or Investigat	tion, in my o	pinion, death occu	rred at the time, o	ate and place,	and due to	the cause(s)
	STATE OF THE STATE	Me	29b. Signeture end title of certifier	with months	rianovi.		29c. Licens	e number		9d. Date signed	(Month	Day, Year)
	HER RED		Danaha A	Manna)		DIS	-		mum		
	1	1	1 Monnohi 10	((10100)			נוע	17)	3	1000000	1 1	(0 1)
1	+1		30. Name and address of person who									
()			PENEUPE P. S		10	U N. BNOS	DWAT	BMD	nuc,	17 21	2-31	
	Sta	_	31. Date filed (Month, Day, Year)	A Property lies	trars Signa	ature						
	Registr	ar	FFD . 2 1000	Gerlin May	14.	17. P. 60.						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Dey **Physician** Month CRUMLISH PATRICK January 30, 1998 7:05 p.m. /Medicai 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Deeth **Examiner** Stella Maris Hospice Center Timonium Baltimore 6. Sex 1 M 2 □ F If Under 1 Yeer 5. Social Security Number If Undar 24 Hrs. 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) **Funerai** Yrs. 46 221-38-7871 Director Nov. 15, 1951 Delaware Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show 7 is merked other than "natural", or items 23a or 28a-f shot traumatic event, the Modical Expresser must be notified at Maryland n/a Baltimore 1X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4613 Walther Ave. 21214 United States deeth Funeral Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter on each of Heelth and Mentel Hygiene.
Int: If Item 27 is marked other than "natural", or Itel
Inty or other traumatic event, I'm Medical Express. 1 Naver Married 2 Married 1 ☐ Yes 2 ☐ No Specify: by White Spacify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedent's Usuel Occupetion (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Bueiness/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Hotel Industry 12 Supervisor Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Surneme) Be John P. Crumlish Wilma Baity 19e. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) David Bentzel / Companion 4613 Walther Ave., Baltimore, MD Baltimore. 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 A Cremetion 3 ☐ Removel from State Department of Important: if any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory 2/2/98 Baltimore, MD 21. Signature of Funeral 22. Name end Address of Facility CAFA Stephen D. Lohrmann P.A. Muran 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Pert1. Enter the diseasa or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical e Liver Failure Examiner Due to (or es e consequence of): Examiner b. Liver Disease Sequentially list conditions, it eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760, c Hepatitis B The law requires thet the death certificate be Physician/Medical Dua to (or as a consequence of) attending p d. HIV (+) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco usa contribute to the cause of death? the been signed by should be detact 1 TYes 2 No 3 Probably 4X Unknown Records, þ 24b. Were eutopsy findings available prior to Completed 24e. Wes an autopsy performed? completion of ceuse of death? 1 Yes 2 No certificete 1 ☐ Yes 2 ☐ No Division of Vital I or Attending Physician: efter death. Director: After this certifice director 25. Was cese referred to medical Be 26. Plece of Death (Check only one) Hospitel: 1 Inpatiant 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 2 1 Yes 2X No funeral 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital
 24 hours e
 Funeral D 1\(\tilde{\textbf{L}}\) Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steled.

2 | Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner steled. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medicai (Check only one) of certifier 29b. Signatura ar 29c. License number 29d. Date signed (Month, Dey, Year) 98 2 . 2 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) TIMONIUM, MD 21093 EDDIE NAKHUDA, MD 2300 DULANEY VALLEY RD. 31. Dete filed (Month, Day, Year) 320 Registrare Signeture Randale State FEB 0 3 1998 Registrar



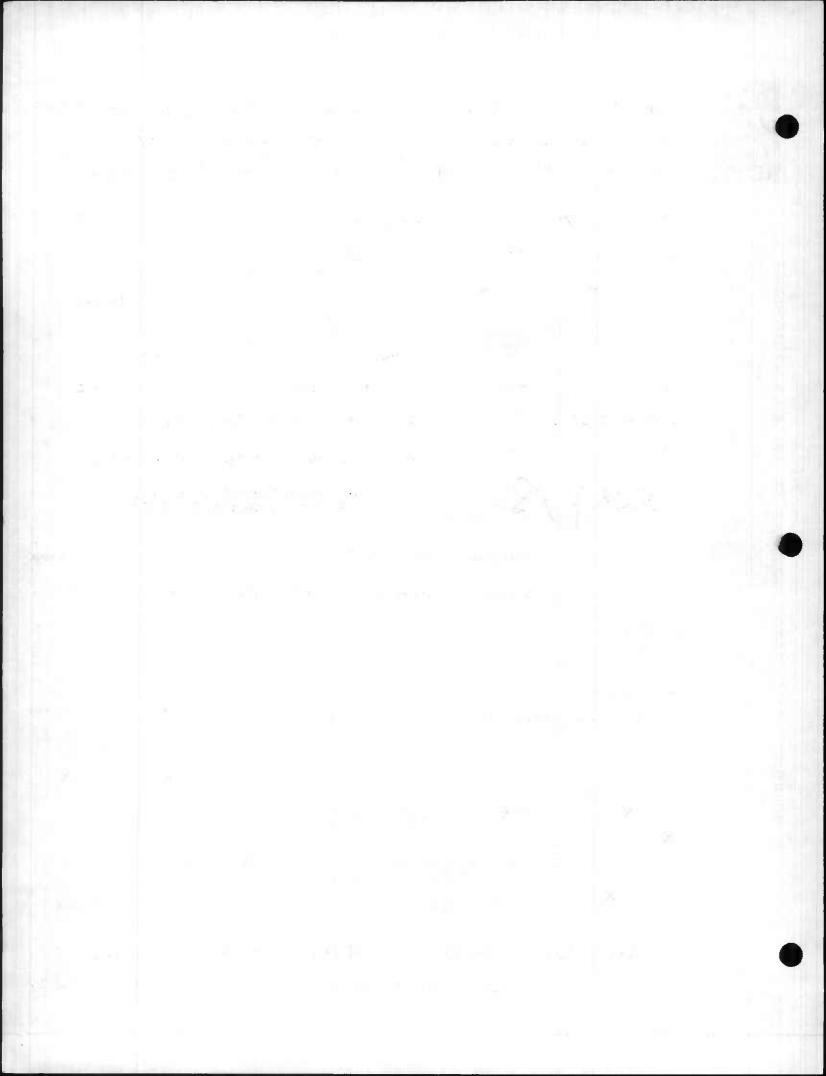
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Date of Daath 3. Tima of Death **Physician** Month Yaar 9:30 PM Chang 29, 1998 January /Medical 4a. Fecility Nama (If not institution, giva street end numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City 5. Social Security Number If Undar 1 Yeer If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Sept. 17 1906 7. Aga (In yrs. last birthdey) Birthplaca (Stata or Foraign Country) **Funeral** 1☑ M 2□ F Yrs. Director 488-98-8031 91 Korea Usual Rasidance of Decedant 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits 28s-f show must be notified at Director 1⊠ Yas 2 No N/A Baltimore City 10e. Streat end Numbar 10f. Zip Coda 10g. Citizan of What Country? ò 11 West 20th St. or thems 23s #13K 21218 USA Funerai 11. Marital Status 12. Was Decedent Ever in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - Amarican Indien, the Medical Examiner Black. White, atc. 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: by Specify: Korean 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Farmer Farming permit. Pages 1 and 2 should be file.
Department of health and Mental Hygh important if flee 27 is marked any injury or other to marked other 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Melden Surname) Suk Woo Chang Kim SSI 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mr. Albert Lee/ In Law 510 E. Preston St. Baltimore, MD. 21202 20b. Place of Disposition (Nama of camatary, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ₺ Burial 2 □ Crametion 3 □ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Meadowridge Cemetery 1-31-98 Elkridge, MD. 21. Signature of Funaral Service Licensaa 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 1050 York Rd. Towson, MD. 23a. Part1. Entar the disaasa, or conclications that causad tha death. Do not antar tha mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Interval Batw Interval Batween Onset end Death **Physician** /Medical Immediate Causa (Final disaasa or condition rasulting in daath) · Cerebral Vascular Accident une week **Examiner** Dua to (or as a consequence of): Examiner Diluted Cardiomyspathy from Severe Mitral Reguly: tation 30 years sician and burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or InJury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medicai Dua to (or as e consaquança of) signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Didbetes Mellitas. Ity pertension Records, by Be Completed 24a. Was en eutopsy performed? 24b. Wara autopsy findings availabla prior to completion of causa of deeth? 2 No 1 ☐ Yes 2 No certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, t 25. Was casa rafarred to madical axaminar? 26. Placa of Death (Check only one) Hospital: 1X Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4 Nursing Home 5 Residanca 6 Othar (Specify) 1 Yas 2 No Certification: To 28a. Data of Injury (Month, Day Yaar) 27. Mannar of Deeth 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accidant 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 - Homicida Medicai 29a. Cartifier Cartifying Phyalcien: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated. (Check only one) 2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) and manner stated. 29b. Signatura and title of certifian 29c. Licansa number 29d. Data signed (Month, Day, Yaar) 2438946 30. Neme end addrass of person who completed cause of deeth (Item 23e) (Type, Print) University Pkwy, Baltimore, MD 21218 201 8. MD Fine Duyden - Randell 31. Data filed (Month, Day, Yaer) 32. Registrar's Signature State 0 2 1998 FEB

DHMH 16 Rev 6/95

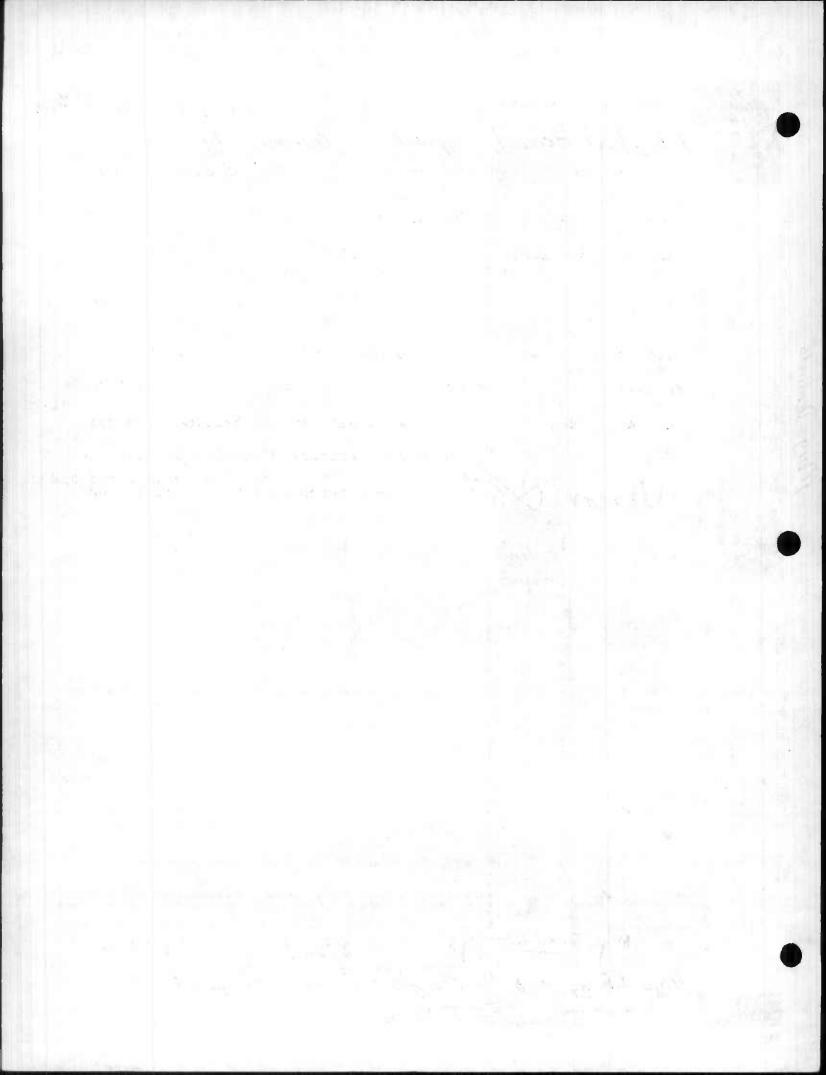
Registrar



State of Maryland / Department of Health and Mental Hygiene 10

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 105 Mary E. Deminds 29 January 1998 /Medical Baltimore U 19
If Under 24 Hrs. 6. Date of Birth (Month, Day, Year) 06-04-18 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give streat and number) 4c. County of Death **Examiner** Genera 7. Age (In yrs. last birthday) H05 NA lana 5. Social Sessity Number If Under 1 Yaar 9. Birthpiace (State or Foreign Country) MD. **Funeral** Days 1 M 2 F 79 Yrs. Director 213-12-6344 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23e or 28a-f show must be notified at Director 1 Yas 2 □ No Md. Baltimore 200 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1351 Woodyear Street 21217 USA Funeral llerns : 12. Was Decedent Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Dacedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes X No Specify: Completed by Specify: 3 Widowad 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygians 11th Grade Laborer G.B.M.C. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Francis Holmes Wallace Lena 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 or other train 2667 Seamon Avenue Baltimore, Maryland Anna K. Parker 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State P☐Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 02-04-98 Woodlawn, Md. 4 ☐ Dolpation 5 ☐ Other (Specify) 21. Signatur 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner onary The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Ihet initiated events resulting in death) Lest P.O. Box 68760, the Due to (or as a consequence of) for use es Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to complation of causa of death? peen 2 No 1 ☐ Yas 2 No this certificate 1 Tas Attending Physician: funerel director. 25. Was case referred to medical Be 26. Plece of Death (Check only one) Hospital: 1 Anpatient 2 ER/OutpatienI 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending investigation 1 Tes 2 No s after deeth 2 Accident in by the 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 6 To the Hospital
within 24 hours a
To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Medicai 29a. Certifler 29b. Signature and title of certifier 29c. License numbar 29d. Date signed (Month, Day, Year) Swe Chane 98 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) co Maryland Chang 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 03 Registrar



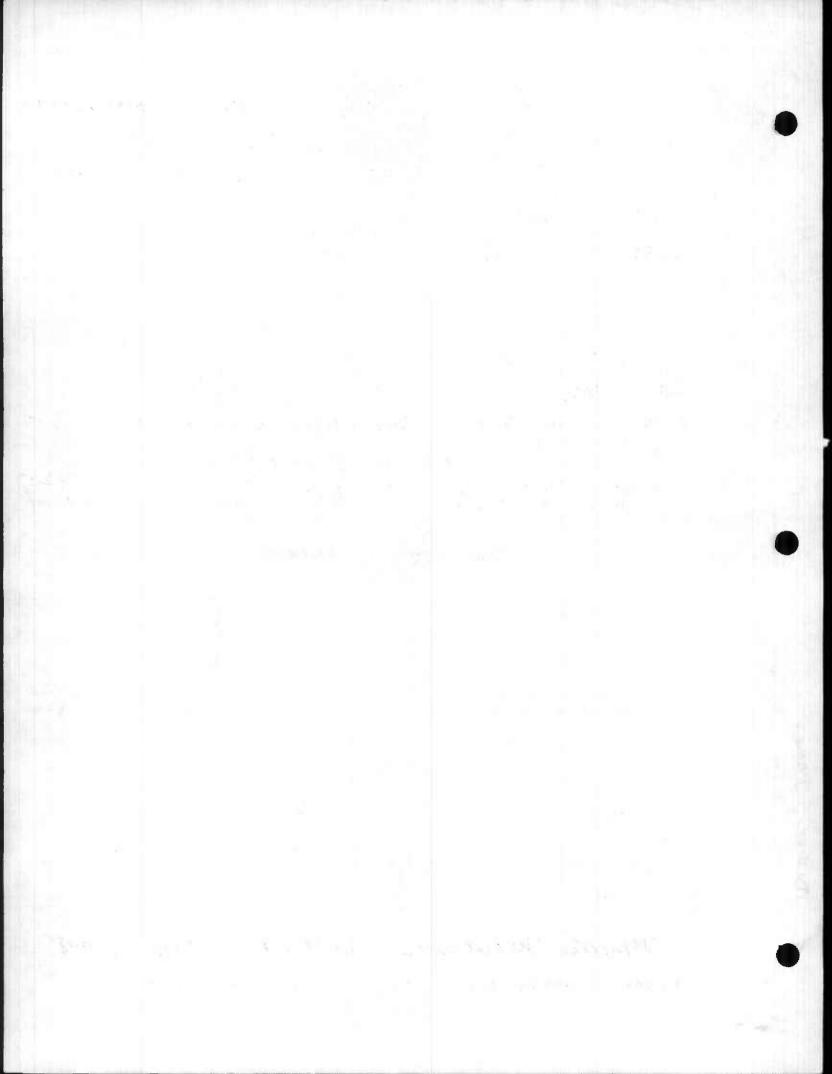
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) -2. Dete of Deeth 3. Time of Deeth Month **Physician** 1028 PM JAN 30 /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** 7. Aga (In yrs. last birthdey) | fl Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | (Month, Dey, Year) N.H evin dale 5. Sociei Security Number 8 Sax Birthpieca (Steta or Foreign Country) **Funeral** 10 M 20 F 76 Yrs. 219-07-9615 Director Usuai Residenca of Decedent the Maryland 10e State 10h Counts 10c. City, Town or Location 10d. insida City Limifs 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examinar must be notified at Baltimore 1 Yas 2 No Director 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? with 1438 ount More Cours 21217 Funeral death permit. Pages 1 and 2 should be filed within 72 hours effer deat Department of Health and Mental Hyglens. Important: If them 27 is marked other than "natural" — any injury or other traumetic even. 12. Was Decedant Ever in U,S. Armed Forces?

1 Yas 2 No If Yes, Give Yeer or Detas: 14. Rece - Amarican Indian, Black, Whita, etc. 13. Wes Decedant of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Meritei Stetus 1 Never Merried 2 Merried Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda complated) 16b. Kind of Business/Industry Tractor Elementary/Secondery (0-12) College (1-4or 5+) 8th grade Driver NA 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Be James KISIE Diggs 19e. informant's Neme/Raietionship (Type, Print) 19b. Meiling Address (Street and Number or Rurei Routa Number, City or Town, Stete, Zip Code) Bertha Sumpter - Sister 4909 EdgeHere Ba Ho, Md Avenue 20b. Place of Disposition (Nema of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 Buriai 2 Cremation 3 Remove from Stata 2-4-98 'enetery 4 □ Donation 5 □ Other (Specify) Zion 21. Signeture of Funerei Sarvice Licensee 22, Name and Addrass of Facility wabash Balto, Ma 300 Perf1. Enfer the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate intervel Between Onset and Death **Physician** /Medical immediete Ceuse (Finei PANCREATIC CANCER WKS diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thef initiated events resulting in death) Last Due to (or es a consequença of): Physician/Medical Dua to (or es a consequance of): USB detached Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Ves 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings availeble prior to completion of cause of deeth? 24e. Wes an eutopsy performed? Completed NA certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Wes case referred to medical axaminer? 26. Piece of Death (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 39No 27. Menner of Deeth 28d. Dascribe how injury occurred 28a. Dete of injury (Month, Dey Year) 28h Time of Certification: 28c. fnjury et Work? 5 Pending Neturef 1 Yes 2 No investigetion 2 Accidant or Attend efter deeth Director: 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date end piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner stated. Medical 29a. Certifier (Check only one) 29b. Signatura and title of cartifiar 29c. License number 29d. Data signed (Month, Dey, Year) Masters Working 2,1998 30. Name end eddress of person who completed cause of deeth (item 23a) (Type, Print) MCNABNEL Betredue Dalt MD MATRIFIL 2434 W. 31. Dete filed (Month, Day, Year) 82 Registrar's Signeture State

Registrar

FEB 0 3 1998



98-0459-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AM RONALD State of Maryland / Department of Health and Mental Hygiene DAVIS Items: 23a part I.27 per MEO G-756 2/11/98 dh Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death Day Month Vaar **Physician** KONALd IRVINGE JANUARY 30, 1998 2:43 P /Medical 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE I Undar 24 Hrs. 1316 KITMORE RD. If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Months Hours Days 180 M 2□ F 50 218 46 8812 Director Usual Rasidance of Dacedant with the Maryland 10a. Stata 10d. Insida City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at Md ALTIMORE 1 Yas 2 No Funeral Director 10g. Citizen of What Country? 10f Zip Coda 10e. Street and Number KITMORE 212 39 4.5. 1316 death 13. Was Dacedenl of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11 Marital Status 12. Was Decedant Evar in U.S. Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married BLACK Baltimore, Maryland 21215-0020 1 Yas 2 No Spacify: Specify À 3 Widowed 4 Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Pagas 1 end 2 should be filed within nent of Haalth and Mental Hygiene. nt: If Item 27 is marked other than ' Elementary/Secondary (0-12) Collega (1-4or 5+) OPERATOR 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) VCILLE DAVIS SIMPSON Joseph 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) LUCILLE md 21239 , TMORE BALTO Rd 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata ŏ 1/7/98 KING mem 4 Donation 5 Other (Specify) 21. Signatura of Funaral Sarvica Licensaa 22. Nama and Addrass of Facility 1304 n. Central 5 Funeral Locks Home 23a. Pad Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final DIABETIC KETOACIDOSIS disaasa or condition rasulting in daath) Examiner Dua to (or as e consequance of): Examiner physician and s the burial-transit thet the death certificate be axecuted Sequentially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Causa (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consaquance of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of): 88 usa 0 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. signed by the 1 Yes 2 No 3 Probably 4 € Unknown by 24b. Wara autopsy findings availabla prior to complation of ceusa of death? 24a. Was an autopsy Completed peen page 2 hes 1M Yas 2□ No 1 Yes 2 No certificata or Attanding Physician: funarai director. 25. Was cesa rafarrad to medical axaminer? Be 26. Placa of Daath (Chack only ona) Othar: 4 Nursing Home Starkasidence 6 Othar (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA MYas 2□ No Lo this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Aftar 1)(X)Natural 5 Panding after death. 1 Yes 2 No invastigation 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Exeminer: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar statad. 29a. Certifier Medical (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifian 29c. Licansa number

State Registrar Strphyn S, 12c
31. Data filad (Month, Day, Year)

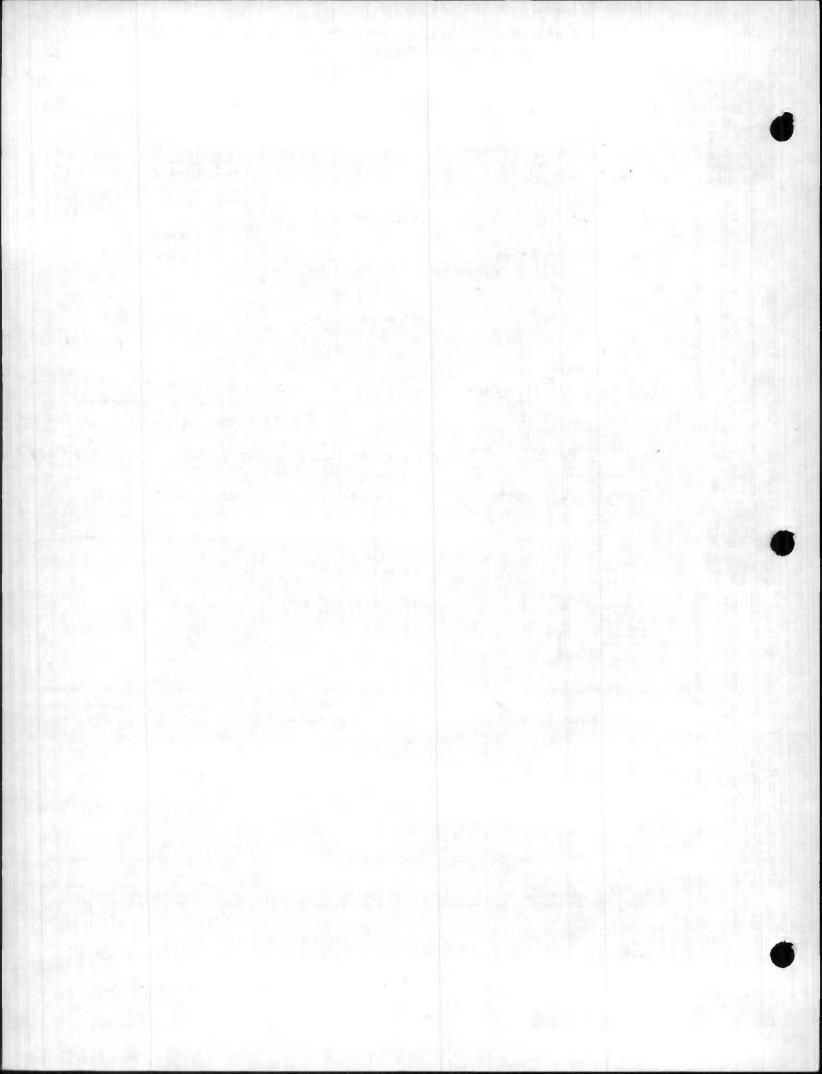
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30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

OCME

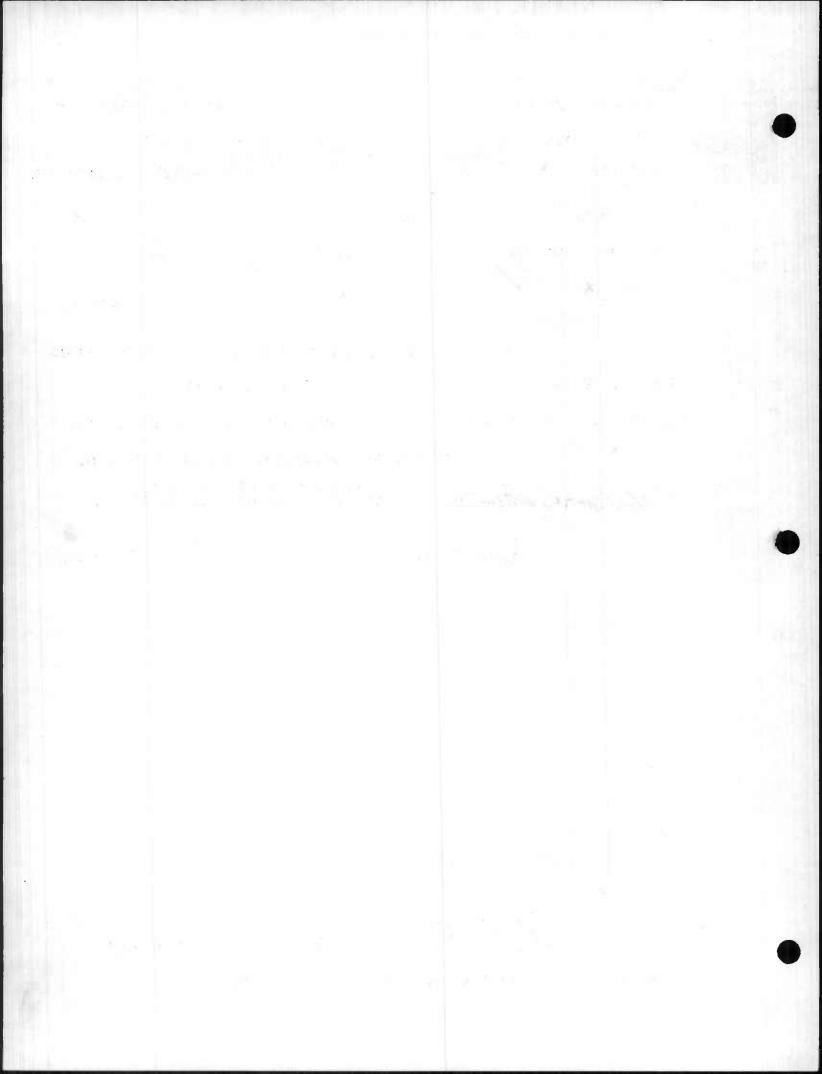
JANUARY 31, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 2933 State of Maryland / Department of Health and Mental Hygiene

Physicia		1. Decedent's Neme (First, Middle,	irst, Middle, Last)						Reg. No.	V.	3. Time of Death
/Medic		JOHN R. DU	NLAP					JANUA:	RY 31,	1998	3:00am
Examin		4e. Fecility Neme (If not institution,	give street end numb	er)			4b. City, Town, or I	ocation of Deeth	4c. County	of Death	
		5219 SPRINGI	AKE WAY				BALTIMO		N/A		
Funeral Director		048-20-2682	. Sex 7.	Age (In yrs.	last birthdey) Yrs.	Months Deys		8. Dete of Birth (Month, Dete 08 – 14 –	7. Year) -1927	9. Birthple Count CONN	ece (Stete or Foreigny) IECTICUT
show		Usuel Residence of Decedent 10a. Stete 10b. County	cation			-	10	d. Inside City Limit			
or 28a-f show	ctor	MD N/A	IMORE				1 PYes 2□				
or 2	Dire	10e. Street end Number				10f. Zip Code			10g. Citizen of Whet Country?		
23	rai	5219 SPRINGLA					212		USA		
, or kem	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 1/4 Yes 2/9 If Yes, Give Year or Date	□No WWT:		Was Decedent of f Yes, specify Cut I ☐ Yes 2 🕱 No	Hispenic Origin? (Spen, Mexican, Puert Specify:	pecify Yes or No- o Ricen, etc.)	Specify	e - Americe ck, White, e	tc.
than "natura the Wedical is ompleted	pa	15. Decedent's	Education	16a Decedent's Usuel (pation		WHITE 16b. Kind of Business/Industry		
	piet	(Specify only highest s Elementery/Secondary (0-12)	rede completed) College (1-4e	or E . \	(Give kind of work done during most life. DO NOT use retired)			nost of working		,	
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9 8		19a. Informant's Name/Reletionship		- \			t end Number or Ru				
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		4 ☐ Donetion 5 ☐ Other (Spe 21. Signeture of Funeral Service Lic		GRI		. Neme end Addr	EMATORY(02/02/9	8 BALT	.O., M	D.
any in		111	0 %	-	_ 1	HENRY W	. JENKI	NS & S	ONS CO		
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 2934 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth February 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE CITY N/A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 1₽ M 2□ F Days Hours 64 Yrs. MAY 30, 1933 10b. County

1. Decedent's Neme (First, Middle, Lest) 3. Time of Deeth **Physician** onzell 12121 Am /Medical 4e. Fecility Neme (If not institution, give street end number) **Examiner** THE JOHNS HOPKINS HOSPITAL 5. Sociel Security Number Birthplece (Stete or Foreign Country) **Funeral** 248-52-8498 Director SOUTH_CAROLINA Usual Residence of Decedent 10e State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 No Director MARYLAND N/A BALTIMORE CITY 10f. Zip Code 10e. Street and Number 1098 CAMERON ROAD 10g. Citizen of Whet Country? 21212 U.S.A. items 23a 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced **NEGRO** Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within tent of Heelth end Mentel Hygiene. nt: If item 27 is marked other than ' BALTIMORE BRICK CO. Elementary/Secondary (0-12) College (1-4or 5+) HT8 LABORER N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumame) IKE DAVIS ELLA PATTERSON 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Heelth er Important: If item 27 is any injury or other trauonce. 1098 CAMERON RD. BALTO, MD. BEVERLY PLUMMER / DAUGHTER 21212 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) BALTIMORE CEMETERY FEB.6,1998 BALTIMORE, MD. 21. Signature of Funerel Service Ligensee CALVIN Address of Facility
B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart feilure. List only one ceuse on each line. Do not enter the mode of dying, such es cerdiac or respiretory errest, Intervel Between Onset end Deeth Physiclan /Medical Immediate Cause (Final disease or condition resulting in deeth) Presumed pulminary embolus
Due to (or es a consequence of): **Examiner** t leg deep venous thrombosis Physician/Medical Examiner week Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest P.O. Box 68760, Due to (or es e consequence of): Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No left sided cerebrovasiular accident þ Prenois deep venous thrombosis 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Was en eutopsy performed? Completed 1 ☐ Yes 2 No Division of Vital 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After Hospital or Attanding 1 Naturel 5 Pending deeth. 1 Yes 2 No 2☐ Accident Investigetion ofter deeth Director: A 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide • Funeral Certifying Phyeiclen: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

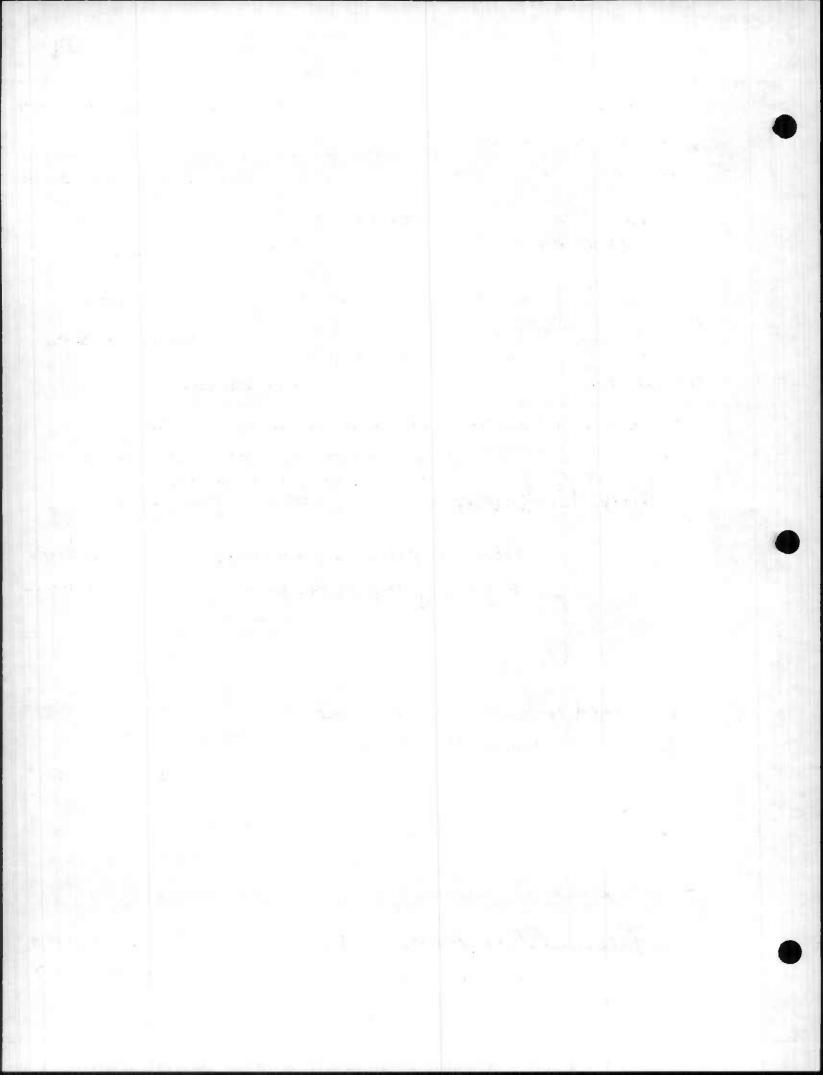
Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner stated. Medical 29a. Certifier To the Vithin 2 To the Complet 29d. Date signed (Month, Dey, Yeer) February 2, 1998 29b. Signeture and little of certifier 29c. License number KES 000 - Changmo Patrice Chang MD Johns Hopkins Hospilal Bultmore MD 21287 31. Date filed (Month, Day, Yeer)

32. Registrar's Signeture

Edia Davidson Pandala

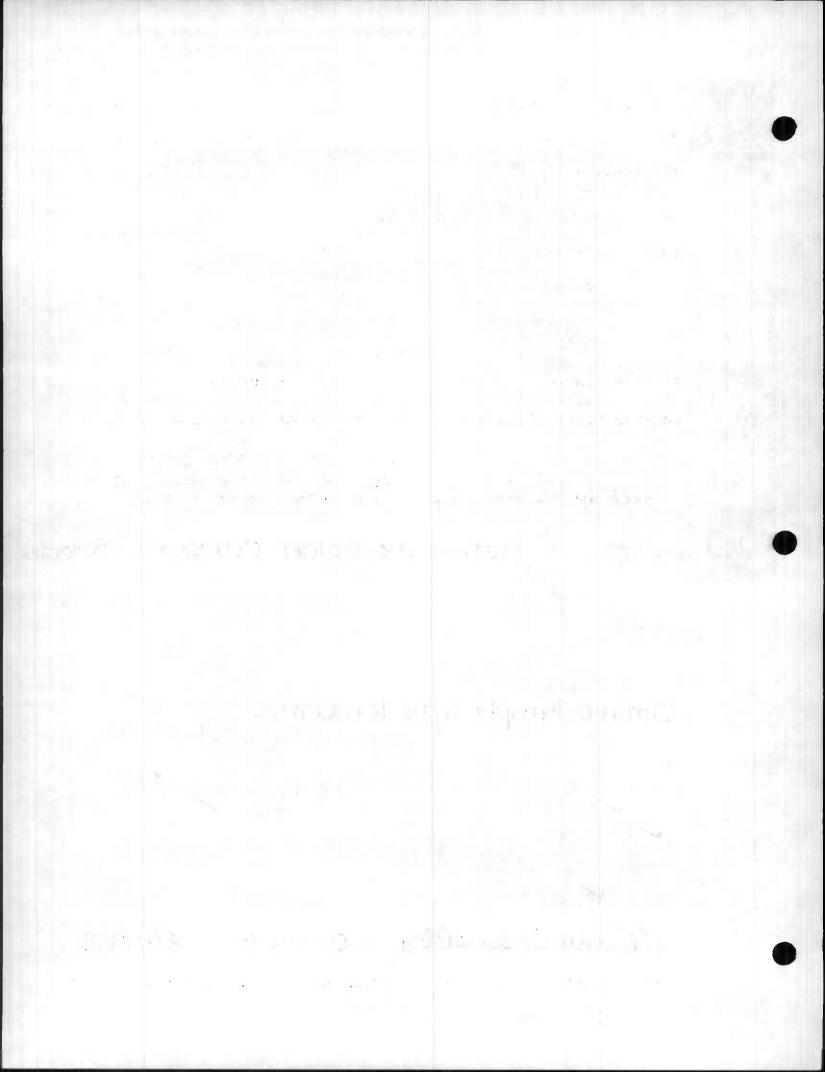
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 8 0 2 9 3 5

						Cei	rtificate	of D	eath		B	leg. No.			
LOW MAN	1. De	cedent's Name (First, Mic	ddle, Last)	Special Co	200		e in				Date of Dea Month	ith Day	112	Yaar	3. Time of Death
Physician /Medical	V	rginia		Diehl							brua			998	11:30 AM
Examiner	4a F	cility Name (If not institu	tion, giva :	street and number	or)			4b.	City, Town		on of Death	-		of Death	
	1	304 Crafto	on Ro	f					Dund	alk		I	Balt	timo	re
Funeral	5. So	cial Security Number	6. Sex		Age (In yrs. la	st birthday)	If Under 1 Months [If Undar 24 Hours	Hrs. 8.	Data of Birth (Month, Day	Year)		9. Birthp	place (State or Foreign
Director	218-22-5690 1 M 2 F 78 Yrs. Months Days Hours Min. (Mor									r 20	r 20 1919 W. Virginia				
2		Residence of Decedent			10- 04	Town and a									
anyle	10a.					Town or Lo									0d. Inside City Limits 1 ☐ Yes 2 No
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or 2	10e.	Street end Number					10f. Zip C					10g. Citi	izen of V	Vhet Cour	itry?
eth v	18	04 Crafto						122					US		
ar de	11. M	arital Status		 Was Decede Armed Force 	s?	5. 13.	Was Deceder If Yes, spacify	Cuban	panic Origir , Mexican, F	n? (Specify Puerto Rica	Yes or No- an, etc.)			a - Ameno k, White,	etc.
72 hours effer deeth with the Maryland naturel', or items 23s or 25s-4 show seal Examinet, must be notified at steed by Funeral Director	1	☐ Never Married 2区 M ☐ Widowed 4 ☐ Divord		1 Yes 2 If Yas, Giva			1□Yes 25	No	Specify:				Specify	Whi	+0
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Physician /Medical Examiner	resul	diate Cause (Final se or condition ing in death)	а	Me		as a consec	C C	010	on	Co	anc	cer	√	-	months
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Year Joesphine Mary Ebert 29 1998 11:13 p Jan. 4a. Facility Neme (If not institution, giva streat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Memorial Hospital Easton Talbot If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Dey, Year) 5. Social Security Number Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthdey) 1 M 2 X F Deys 86 Yrs. 220-50-4922 November 1,1911 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Dorchester Maryland 1 ☐ Yes 2 No Cambridge 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21613 5600 Ross Neck Rd. United States 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ Nevar Merrled 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorcad 15. Decadent's Education (Specify only highest grede completed) 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 homemaker own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumema) Paul Belbot Wanda Sobus 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Donna Dippel/daughter 1208 Marywood Ct. Bel Air, MD 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Ramovel from State 4 ☐ Donation 5 ☐ Othar (Specify) Most Holy Redeemer Cemetery 2/4/98 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Home. Inc. 6500 York Rd. Baltimore, MD 111. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heer failure. List only one cause on each line. Immediate Ceuse (Final disaase or condition resulting in death) 20-30 Win and Due to (or es e consequença of): Dua to (or as a consequanca of): 23b. Did tobacco usa contribute to the cause of death? 1□ Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No

Physiclan /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0020

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Physician/Medical Examiner by Completed Be P

The law requires that the death certificete be executed Box 68760, the be deteched for use es Division of Vital Records, P.O. or Attending Physician: this funeral efter deeth. Hospital 24 hours e Funeral D completely To the Within 2

Sequentially list conditions, if eny, leeding to Immediata cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last Pert II. Other significant conditions contributing to daeth but not resulting in the undarlying ceuse given in Pert I. 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Dete of Injury (Month, Dey Yaar) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Neturel 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homlcide 29a. Certifier (Check only one) Cartifying Phyalcien: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year)

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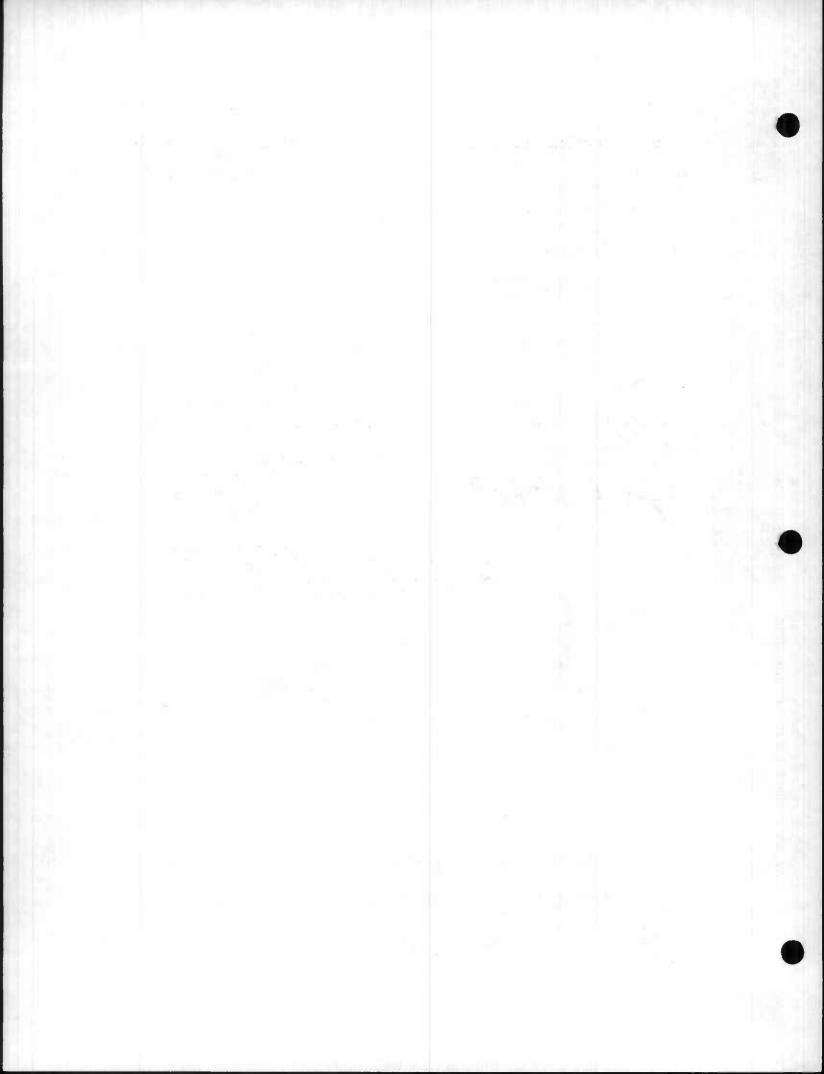
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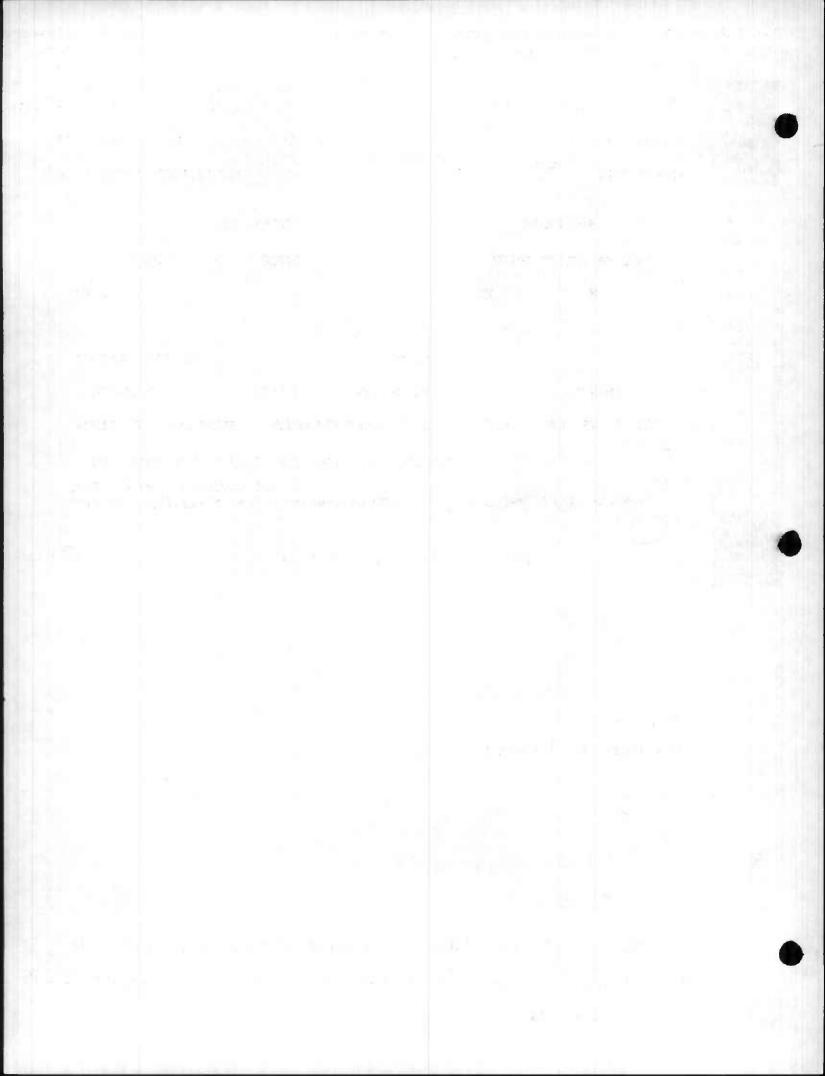
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30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 8

					Ce	ertificat	te of	Death		R	eg. No.	U	201
Phys /Me	ician dical	1. Decedent's Name (First, Middle, Joseph Eis		3	H	1,0				2. Date of Dea Month Februa	h Day	1448	3. Time of Death 1:05 p
	niner	4a. Fecility Name (If not institution, Sinai Hosp		nber)									e City
Funer Directe		210-12-1422	6. Sex XX M 2□ F	7. Age (In yrs. 74		Months			24 Hrs. Min.	8. Date of Birth (Month, Day MAY 13	, 1923	9. Birthp Coun RHODE	elace (State or Foreig etry) E ISLAND
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD BALT	IMORE	10c. Ci	ity, Town or L	ocation.		pΤ	KESV	ILLE		1	0d. Inside City Limits
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d 2 should be th and Mental 7 is marked o traumatic eve	2	P ABRAHAM EISENBERG N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nur							LLIE			ELILOV	
EENF		FRIEDA EISEN		FE	The Control			F DRI			MORE, N		1208
500		20a. Method of Disposition 1 Bunal 2 Cremation 4 Donation 5 Other (Sp.		State	Place of Disposemetery, creemetery, creemetery	oosition (Na ematory or o	me of other pla	ice)		Dete	20c. Location	- City or To	wn, State
permit. Pege Department of Important: If eny Injury or	SUCE	21. Signature of Funerel Service L	icensee		2	22. Name a	nd Addr	ess of Facilit	sol	Levins	on & Br	cos.,	Inc.
Physicia	n	234 Part Er er the disease, or or hock, or leart failure. List of	complications that conly one ceuse on e	aused the dea ach line.						oad Pike or respiratory arm		e, MD	Approximate interval Between Onset and Death
/Medica Examine	er	Immediate Cause (Final disease or condition resulting in death)	e my	OCCUP Due to (dial or as a conse	equence of)	ar	ction	n				~ 12 hr
The law requires that the death certificete be axecuted at has been signed by the attending physician end page 2 should be detached for use as the bunal-transit	VMedical Examiner	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Infliated events resulting In death) Last	b		or es e conse		:						
a daath cert the attendin hed for usa	Physician/	Part II. Other algnificant condition	s contributing to de	ath but not res	resulting in the underlying ceuse given in Part I.				23b. Did tobacco use contribute to the cause of			the cause of death	
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To the within 2 To the comple	₩ W	29b. Signature and title of certifier 29c						ense number 29d. Date signed (Month, Day, Yet 402321MP9522 February 1, 1992				Day, Year) 1998	
12		30. Name and address of person w Maria Prince	no completed ceus	of deeth (Iter	m 23a) (Туре								
S Regis	State strar	31. Date filed (Month, Day, Year)	32. R	gistrar's Signa	ature					~			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Yaar MARIE **EGLISKIS** 29 January 1998 3:40 am 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium If Undar 24 Hrs. 8. Date of Birth (Month, Day, Yaar) If Under 1 Yeer 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplece (Stata or Foraign Country) Days 1 ☐ M 2 🖾 F Yrs. 178-03-2071 84 Feb. 10, 1913 Germany Usual Rasidance of Dacedan 10a Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Baltimore Phoenix 10e. Street and Numba 10f. Zip Coda 10g. Citizan of Whet Country? 2126 Highland Ridge Dr. 21131 IISA Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 No If Yas, Give 1 □ Never Merried 2 □ Married 1 ☐ Yas 2 No Specify: Specify: White lt Yas, Give Yaar or Datas. 30€ Widowed 4 Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) 9 Assembly Line Paper Mill 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumema) Chervenka Unknown Marie Henry 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat end Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Mr. Bernard J. Eglikis/son 2126 Highland Ridge Dr. Phoenix, Md. 21131 20b. Place of Disposition (Nama of cematery, crametory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☑Buriai 2 ☐ Cramation 3 ☐ Ramovai from State 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph Cemetery 2/2/98 Duryea, Pa. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 Enter the disaesa, or complications that caused the daath. Do not enter the mode of dying, such es cardiac or raspiretory errast, shock, or haart failura. List only ona causa on aach lina. Approximate Interval Batwaan Onsat and Death Immedieta Causa (Final diseasa or condition rasulting in death) Cardiovascular Disease Due to (or as a consaquance of): Diabetes Saquantially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): Dua to (or es e consaquance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy parformad? 24b. Wara autopsy findings availabla prior to completion of cause of daath? 1 Yas 2 No 25. Wes casa rafarrad to medical axeminer? 26. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Deeth 28e. Date of Injury (Month, Day Yaar) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred 5 Pending Invastigation 1. Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 🚅 Certifying Phyalcian: To the best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar es statad. 29a. Cartifiar 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, end due to the ceuse(s) and mannar stated. 29b. Signeture and the at on Hiar 29c. License number 29d. Data signed (Month, Day, Year) ny 1. 69. 48

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Timonium, Md 21093

Box 68760, EGLISKIS P.O. MARIE Records, ROSE Vital Division of NAME:

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Baltimore, Maryland 21215-0020

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30. Nama and addrass of person who completed cause of death (Item 23e) (Type, Print)



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** JANUARY D345 1998 FRANK FISHER 6:05 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4c. County of Death Baltimore Examiner If Undar 24 Hrs. If Under 1 Yaar 8. Data of Birth (Month, Day, Year) April 19, 1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2□ F 107-09-4077 82 Yrs Director Maryland Usual Residence of Decedent the Merylenc 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinal must be notified at 1 ☐ Yas 2 ☑ No Maryland Baltimore Baltimore Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1114 Arran Road 21239 permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a any injury or other traumatic event. United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 MNo If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2X No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Manager 18. Mothar's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Be Frank Benjamin Fisher Elsie Blanch Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marion Beatrice Fisher/Wife 1114 Arran Road Baltimore, Maryland 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 Cramation 3 Ramoval from Stata Dulaney Valley Mem. Gar. 2-2-98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Home Teven 1. Bittle 6500 York Road Baltimore, MD 21212 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** END STAGE CARDIOMYOPATHY 18 MONTH /Medical Immediate Cause (Final diseasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner ATHEROSCLEROTIC CARDIOVASCULAR DISEASE YEARS the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) as esn 0 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown BRONCHOGENIC CARCINOMA à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of ceuse of death? page 2 s 2 No 1 ☐ Yes 2 No certificate or Attending Physician: funeral director, Be 25. Was case referred to medicel examinar? 26. Place of Death (Check only one) TO Yes 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 10 1 Inpatient 2 □ ER/Outpatient 3 □ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? Natural 2 Accidant 5 Pending within 24 hours after death. To the Funeral Director: Al 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier Medicai 🛣 Cartifying Physician: To the best ot my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. To the 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person into completed cause of seath (Item 23a) (Type, Print) BEATRIZ P. DIZON, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar 31. Date filed (Month, Day, Year)
FEB 0 3 1998

33 Punistrar's Signature

Juni Davidson-Randalla

D. A. Bethard V.

State of Maryland / Department of Health and Mental Hygiene

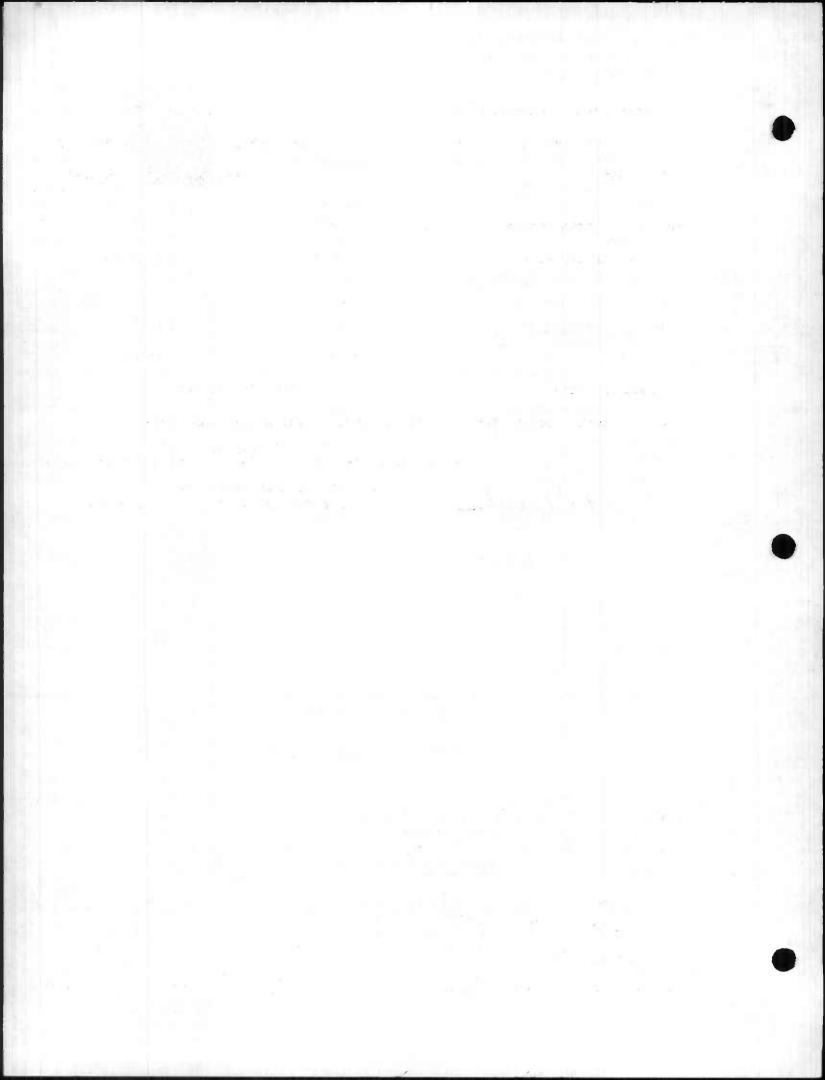
Certificate of Death Reg. No. 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Genevieve L. Feuchtenberger January 30, 1998 8:30 A.M. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Yaer If Undar 24 Hrs. 8. Deta of Birth
Months Deys Hours Min. (Month, Day, Year) 9. Birthpieca (Steta or Foreign Country) New York 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 XF Yrs Director 212-42-9505 90 Mar. Usual Residence of Decedent with the Meryland 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at 1 ☐ Yas 2 No Director Maryland | Anne Arundel Arno1d 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 812 Waterview Ave. 21012 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 11. Marital Stetus 14. Race - American Indian. filed within 72 hours efter 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No White Specify: þ Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filk Department of Heelth and Mental Hy Important: if flem ZT is marked oth any linjury or other traumatic event Spice. 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Melden Sumeme) Emmanuel Shaver Cicilia Coleman 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Joseph Feuchtenberger/Son 812 Waterview Ave. Arnold, Md 21012 20b. Plece of Disposition (Nema of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Februar Pete 2. 1 Burial 2 □ Cremetion 3 □ Removal from State Glen Haven Mem. Pk. 1998 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Funerel Sarvice Licensee 22. Name and Addrass of Facility
Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie 21061 Part : Enter the disease, or complications in a ceused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart feiture. List only one ceuji on each line. Approximate Interval Between Onset end Deeth 1/3/ **Physician** Immediete Cause (Finei disease or condition resulting in deeth) udrund /Medical Res pirator 1 STYESS Examiner Due to (or as e consequence of): Examiner Jacumo 100 Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in daath) Last (or as a consequence of) pcrea nicu Physician/Medical Dua to (or as a consequance of): the s Part II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part i. 23b. Did tobacco use contribute to the cause of death? page 2 should be deteched 1 Yee 3 No signed by 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy Completed peen hes 1 Tes 1 TYes 2 No. certificata 25. Was casa referred to medical examiner?

1 Yes 2 No funeral director. Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 9 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Tima of Certification: 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation OZOA M 1 Netural tell death. 1 Yas 2 No Dlind contused 24 198 2 Accident 28f. Location (Street and Number of Rural Routa Number, City of Town, State)

570 Bellevive Dr. # 334

Annapolis Md. 2140 after death 3 ☐ Sulcida 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 8 home 24 hours a Funeral D 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and many place. Medical To the I 29b. Signature and little of certifie 29c. License number D41816 MD. 30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print) AAMC Franklin St. Hunapo 64 Harles M.D. 32 Registrar's Signeture 31. Date filed (Month, Dey, Year) State Julia Deviden Rendall 0 3 1998 Registrar FEB



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item #9 perFH G756 2/3/98 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth **Physician** Month 1998 FELD 30, JAN. 12:30 AM /Medical 4e. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner HOSPICE OF BALTIMORE-GILCHRIST CENTER TOWSON If Under 1 Year If Under 24 Hrs. BALTIMORE 8. Date of Birth Month, Day, Yaar MAY 21, 1924 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□ M 2□x5x Months Deys 73 Yrs. Director 036-16-1182 ISLAND 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at MD BALTIMORE Director BALTIMORE 1 Yes 2 X 10e. Straet end Number 10f. Zip Code 10g. Citizan of Whet Country? ŏ 3513 MARYVALE ROAD Herns 23a 21244 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 (X) Yo if Yas, Give Yeer or Detes: Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Stetus should be filed within 72 hours after nd Mental Hyglena. merked other than "natural", or ite 1 Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 🛛 📉 o Specify WHITE þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) 12 HOMEMAKER OWN HOME Baltimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middla, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental JULIUS ELY MOLLIE KUSHNER 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street end Numbar or Rural Route Number, City or Town, State, Zip Code) If item 27 is HERMAN FELD / HUSBAND 3513 MARYVALE ROAD, BALTIMORE, MD 21244 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Suriei 2 ☐ Cremation 3 ☐ Removel from Stata permit. Page Department of Important: If any injury or once. OHEB SHALOM MEMORIAL PK FEB.1, 1998 REISTERSTOWN, 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Fugural Service License 22. Nama and Address of Fecility SOL LEVINSON & BROS, INC. 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208 tha disease, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiretory errast, art failure. List only one cause on each lina. Approximata intervel Betw **Physician** multiple myeloma /Medicai Immadiata Cause (Finel 6 month diseesa or condition resulting in death) Examiner Sequentially list conditions, if eny, leeding to immediate causa. Entar Undarlying Cause (Diseese or injury that inflieted evants resulting in daath) Lest Due to (or es e consequence of): 68760 Physician/Medical Dua to (or as a consaquence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying ceusa givan in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings evelleble prior to completion of causa of death? Completed 24a. Was en eutopsy performad? 213 No 1 ☐ Yes 2 ☐ No Vital Be 25. Was casa referred to medicel 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospice Medical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3□ DOA ö 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? Division Naturei 5 Pending investigation 1 Yes 2 No 2 Accidant 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicida 29a, Certifier Certifying Physicfen: To tha best of my knowledga, daath occurred et the time, dete end piace, and due to the ceuse(s) end mannar as stated.

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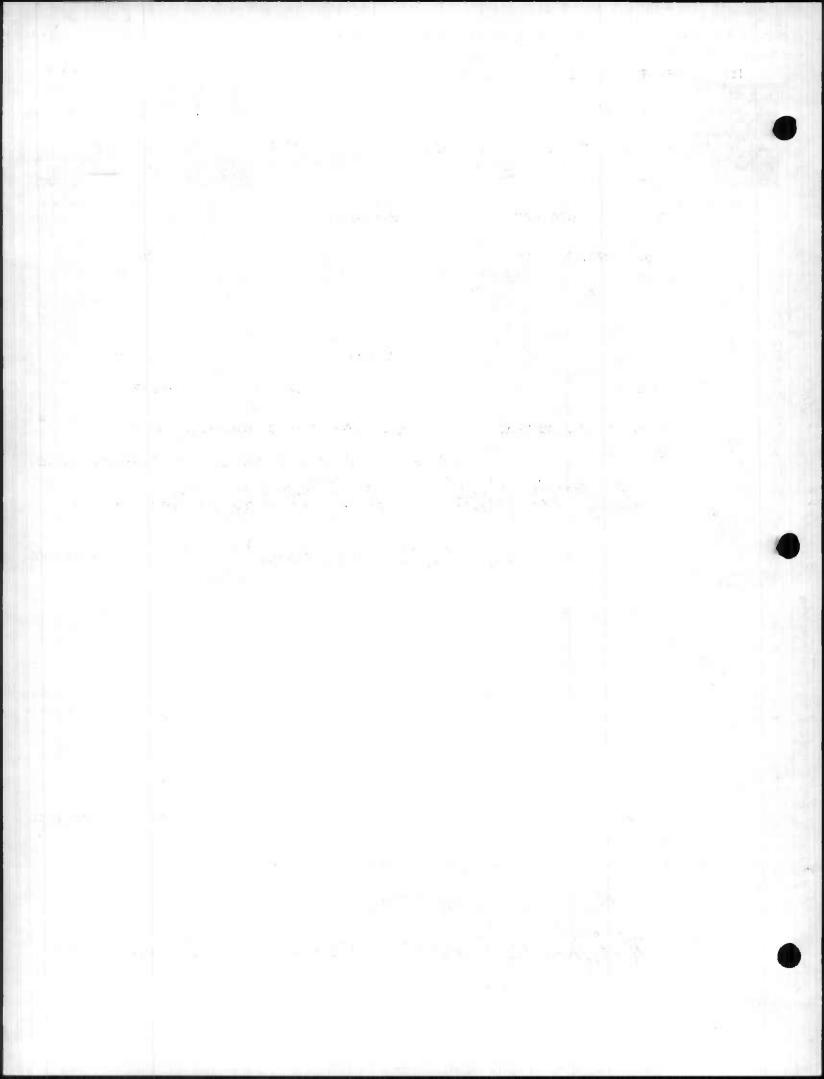
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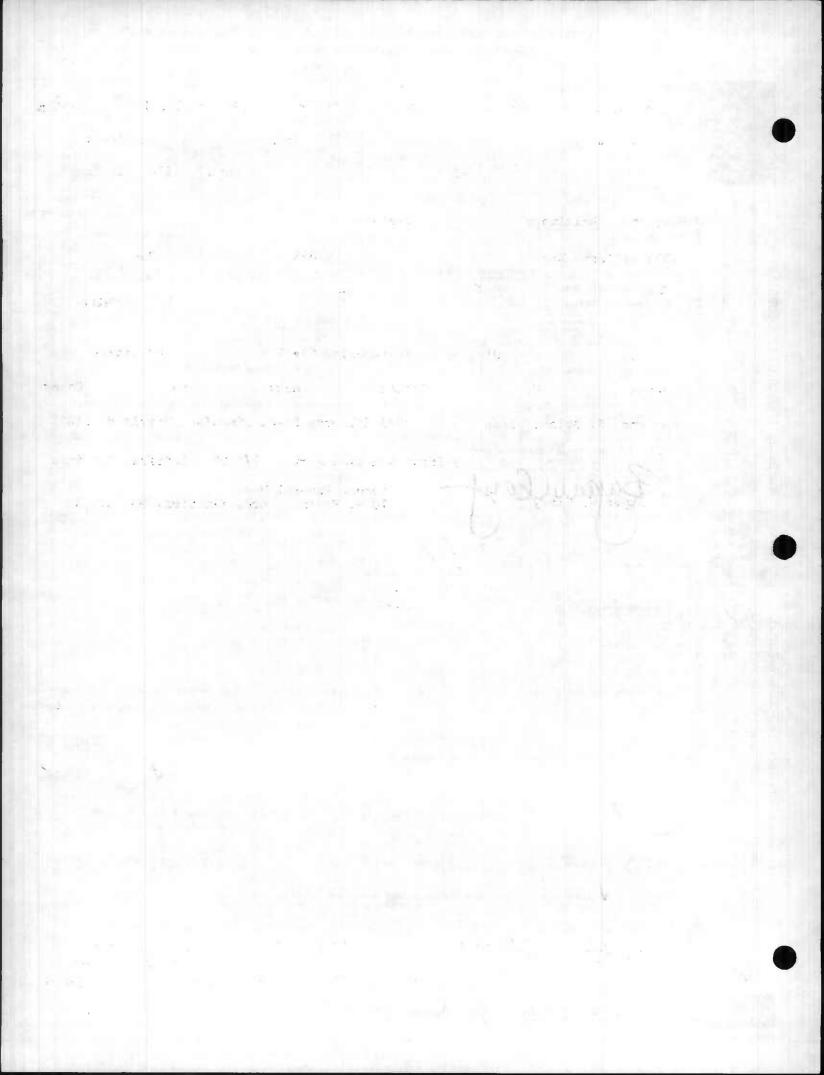
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Funeral Director	5. Social Security Number 6. Se 579-10-4665 Usual Rasidence of Decedent	7. Age (in yi	Yrs. last birthdey) If Und Month			1900 I	Sirthplece (Stete or Foreigi Country) ndiana			
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and No	19e. Informant's Name/Reletionship (T)	vpe, Print)	19b. Mailing Addre	ess (Street end Number or F	Rurel Routa Number	r, City or Town, State	e, Zip Code)			
and 2 patth and 27 is	Marianne S. Brigh	t/Niece	2323 K	illoran Road,	Timonium	, Marylan	d 21093			
of Head	20a. Method of Disposition		. Place of Disposition (/ cemetery, cremetory	Vame of or other place)	Date	20c. Location - City	or Town, State			
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	a. CV	A				Onset and Death			
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physical Examiner	Cause (Disease or injury that initiated events	C	(24.00.0.0000000000000000000000000000000							
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The law ate hes b page 2 s					1 🗆 Y	es 2 No	1 ☐ Yes 20 No			
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To the company	29b. Signature and titla of certifier	4		29c. Licansa number		9d. Data signed (Mo				
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60	30. Name and eddress of person who co		tem 23a) (Type, Print)	D25680		EBAR	HIM			
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State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** HARRY RAYMOND GILNER February 1, 1998 3:55A /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Death 114 Upnor Road Baltimore N/A 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) **Funeral** 1 M 2 F Months Deys Hours Yrs. Director 212-07-7745 94 August 6, 1903 Maryland Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County worle 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryla Department of Heelth and Mentel Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ehow with injury or other treumatic event, the Medical Exarticer must be notified at once. Yes 2 No Funeral Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 114 Upnor Road 21212 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 12. Wes Decedent Ever in U.S. Armed Forces? 14. Rece - American Indien. Bleck, White, etc. 1 ☐ Never Merried X Merried Yes 2XXNO altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Salesman Food 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Harry Joseph Gilner Mary Teresa Callahan 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 18 Alco Place Baltimore, Maryland 21227 Harry Raymond Gilner Jr Son 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete Burial 2 ☐ Cremetion 3 ☐ Removei from Stete
Donetion 5 ☐ Other (Specify) St Mary's Cemetery 2/3/98 Baltimore, Maryland nature of Funeral Service 22. Neme end Address of Fecility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervai Between Onset end Death **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner Lova The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last the buriel-trar Due to (or es e consequence of): P.O. Box 68760, attending physician for use es the bure Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ page 2 should be 24b. Were autopsy findings avelleble prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? peen mention of algherra a Trafe certificate hes 1 ☐ Yes 2 ☐ No 1 Yes 2000 Attending Physician: Be 25. Wes case referred to medical examiner? 28. Pieca of Deeth (Check only one) Other: 4 Nursing Home 5 Septendence 6 Other (Specify) 10 1 Yes 2.00 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this To the Hospital or Attending Phywithin 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral. 28c. Injury et Work? 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how Injury occurred Naturei
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, and due to the cause(s) end menner stated. 29e. Certifier 29b. Signeture end title of gertifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and address of person who completed cause of death (item 23a) (Type, Print) 21204 WALTER R. WE 31. Dete filed (Month, Dey, Year) WELZANT M.D. 7600 OSLER DR STE 107

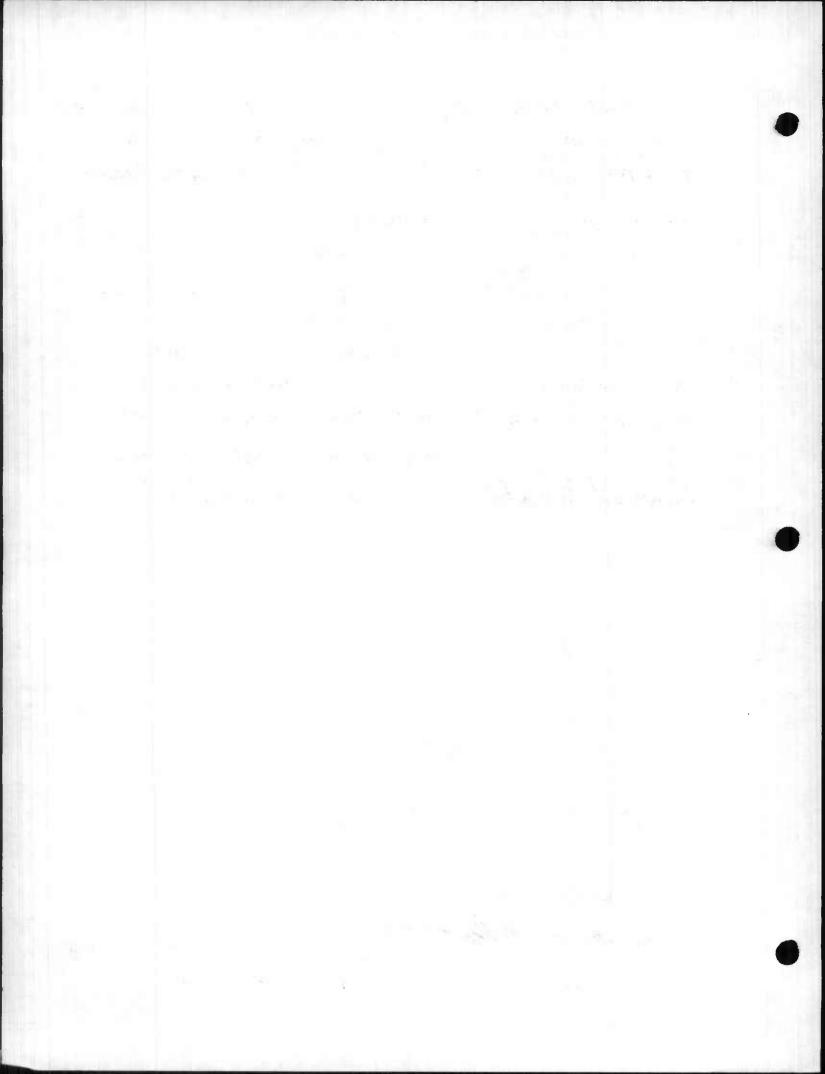
32. Registrer's Signeture

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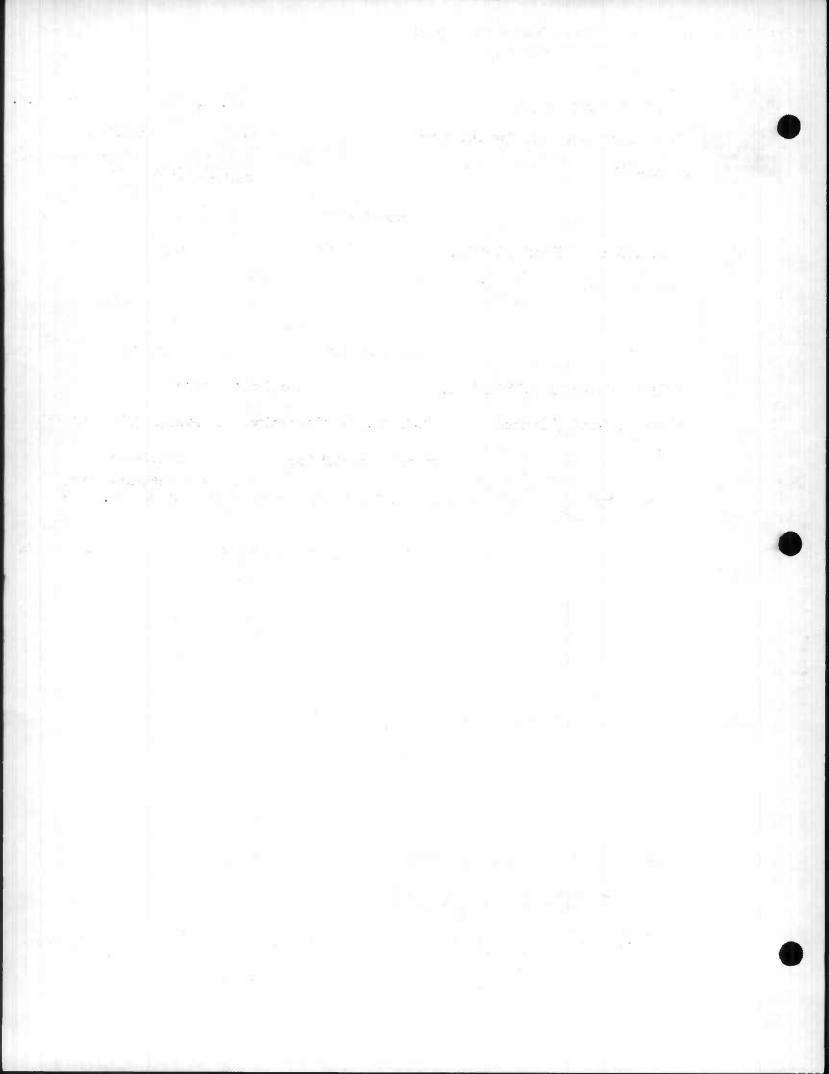
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	_	0a. Stete 10b. Co			10c. C	ity, Town or Lo	cation				10	d. Inside City Limits	
ctor		PA Ac	ams			Ar	endtsvil	le				1 ☐ Yes 2 📉 No	
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		1 Surial 2 ☐ Creme 4 ☐ Donetion 5 ☐ Oth			State	cemetery, cren	netory or other plea			Balti		, 51010	
any injury once.	100	1. Signature of Funeral-Ea					Memoria. Name end Addre		1100/			a Dd	
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edical Examiner	93.11	esulting in deeth) Sequentielly list conditions, eny, leading to immediate ause. Enter Underlying Souse (Disease of Injury hat initiated events	{	b	Due to	(or es e consequence or es	uence of):						
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sici	P	ert II. Other significent cor	ditions co	ntributing to d	leath but not re	sulting in the ur	nderlying cause giv	en in Part I.	23b. Dld	tobacco use co	ntributa to 1	the cause of death?	
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o Be		 Was case referred to me exeminer? 1 ☐ Yes 2 No 	-	Hospitel:	Innational OF	7 ED (0. 41)	Oth	or:	eth (Check only			11-00	
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edical	2	9a. Certifier 12 Cer (Check only one) 2 Med	ifying Phy Ical Exam	Inar: On the b	esis of examin	owledge, death etion end/or inv	occurred et the tin estigetion, In my o	ne, date end plec pinion, deeth occ	e, end due to the curred et the time,	ceuse(s) end me date end place,	enner es ste end due to t	ited. the ceuse(s)	
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		11.11	1.00	THE PROPERTY OF	/ /								
		0. Neme end eddress of pe		ompleted du	se of death (Ne	AL. C	Print) Lances Si	L. Bal					

Nacus Gerald



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Daath Month GARRETT JUNE JANUARY 4a. Facility Nama (If not institution, giva straat and numbar) 4b. City, Town, or Location of Daath 4c. County of Death BAYVIEW SALTIMORE If Undar 24 Hrs. 8. Data of ITOPKINS MEDICAL A LENTER If Undar 1 Yaar 5. Social Sacurity Numbar 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) 1□M 2♥F Months Days Hours Yrs. 217-18-1138 79 June 13, 1918 Maryland Usual Residence of Decedani 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☑ No Maryland Baltimore Dundalk 10a. Straat and Number 10f. Zip Code 10g. Citizan of What Country? 6510 Baltimore Avenue 21222 United States 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Race - American indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☐ No Specify: Spacify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 8 years Tin Mill Worker Steel Industry 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meiden Sumama) Paul Snyder Anna Langle 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2712 Creston Road Mrs. Margaret Wright (Daughter) Baltimore, Maryland 21222 20a. Mathod of Disposition 20b. Piace of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Molly Hill Mem.Grdns. 2/2/1998 Middle River, Maryland 21. Signature of Funaral Sarvica Licensaa 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Jaryland 21222 23a. Part / Enter tha diseasa, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final ROSEPSLS 24 HOURS disaasa or condition rasulting in death) Dua to (or as a consaguance of): Dua to (or as a consequance of): 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to RENAL FAILURE 24a. Wes en autopsy performed? complation of causa of deeth?

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "ny any Injury or other traumatic event, The Megil pine.

Physician

/Medical

10a. Stata

Examiner

Funeral

Director

28a-f show

Director

Funerai

Completed by

Be

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an "natural", or items 23e or 28e-f st Medical Examiner must be notified

the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

Examiner Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Ceusa (Disaasa or injury thet initiatad avants rasulting in daeth) Lest Physician/Medicai

Be Completed by

that the death certificate be executed 950 for ned by sign 1 be page 2 should the Hospital or Attanding Physician: thin 24 hours after death.
the Funeral Director: After this cartifica mpletely filled in by the funeral director, it Certification: To

To the Hospital of within 24 hours at To the Funeral Completely filled Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. EMENTIA 1 Yas 1 Yes 20 No 25. Was casa referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Yas 2 No 1 Hopatiant 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be determined 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 3 Suicida 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, State) 4 Homicida Certifying Physicien: To the best of my knowledge, daeth occurred et the time, dete end place, and dua to the ceuse(s) end menner as steted.

Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier 29b. Signatura a 29c. Licansa number 29d. Date signed (Month, Dey, Year)

BAYVIEW MEDICAL

8 State Registrar

31. Data filad (Month, Day, Yaar) 0 3 1998 FEB

30. Nama a

32. Registrar's Signatura This Davidson-Randoes

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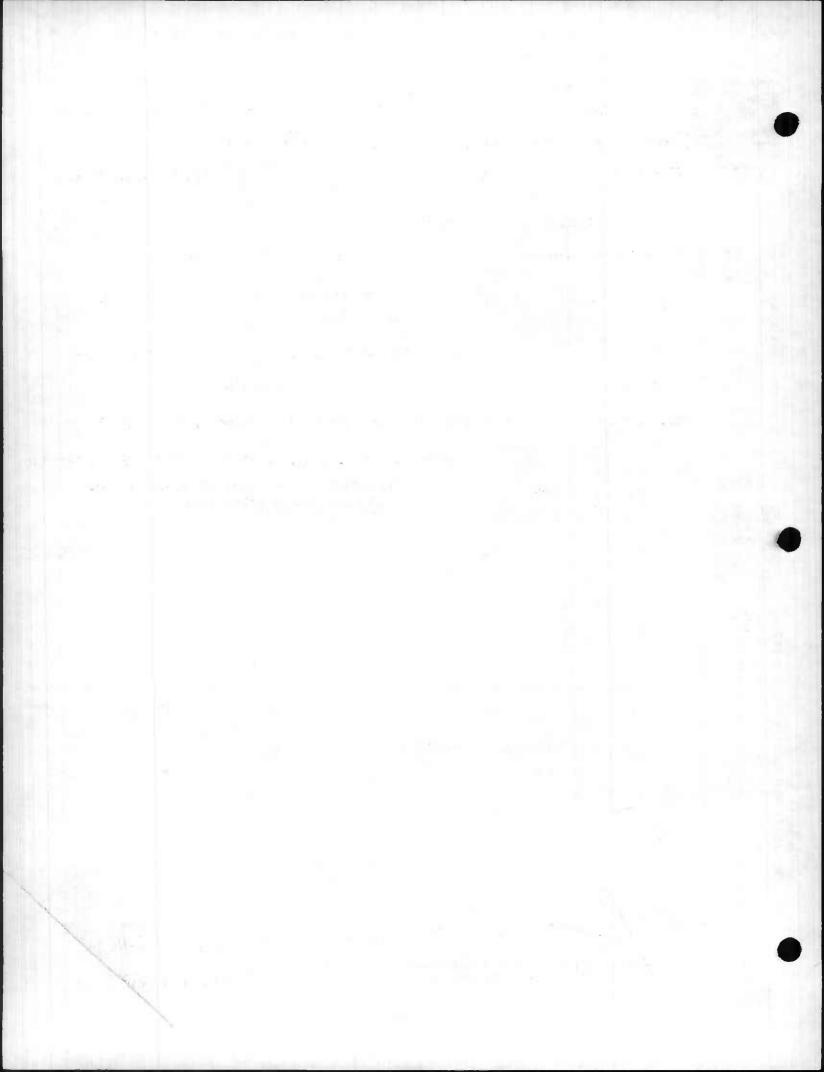
DRS. WONAM, MD

sound

nd addrass of person who completed ceuse of death (Itam 23a) (Type, Print)

J. WENAMI

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death **Physician** January 30 1998 eer Gerber The 1 ma 11:40PM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Timonium Baltimore Stella Maris 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) March 4 1911 5. Social Security Number 9. Birthplece (State or Foreign **Funeral** Months Hours Country) Maryland 1 □ M 2 🖺 F 86 Yrs. 217-64-3667 Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 23a or 28a-f show Timonium Baltimore 1 ☐ Yes 2 No Director MD Examiner must be notified 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21093 2300 Dulaney Valley Rd. Funeral Items 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛂 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 natural', or 1 ☐ Yes 2 No Specify: White Specify: by 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be filt Depertment of Health end Mental Hy Important: If item Z7 is marked oth any linjury or other traumatic evant once. 18. Molher's Name (First, Middle, Meiden Surneme) Be Fishpaw Alverta Phipps Edward 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5907 Grace Lee Ave. Sykesville, Md. 21784 Mrs. Victoria Powell/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State Jessop Meth. Church Cem. 2-2-98 Cockeysville, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licens 22. Name and Africas of Facility uneral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, oxemplications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final ATHEROSCLEROTD CARNOVACULAR disease or condition resulting in death) Examiner DISCAS-Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 0 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ۵ BMBNTA signed b à Records. 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed 1 Yes 21 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: effer death. Director: After this certific 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident actor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours of Funeral Dietely filled in Certifying Phyeiclen: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner steted. Medical 29a. Certifier (Check only one) To the To the Complet 29c. License number 29d. Dale signed (Month, Dey, Yeer) 29b. Signeture end pain of contain D25686 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) ERRIMIM IP/TICLE! 7600 05050 Daire, BATIMORE MOZIZO4

State Registrar 31. Date filed (Month, Day, Year) FEB 0 3 1998 32. Registrar's Signeture Autia Davidson-Randell

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\begin{align*} \begin{align*} \emptyre & \text{Proposition of Health and Mental Hygiene } \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health and Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \emptyre & \text{Proposition of Health And Mental Hygiene} \empt Certificate of Death Item#4a, RER, Phy, 10e, 10f per FH G756 2/3/98 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death GOOD MAN 6:00AM VAN. 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death BALTIMORE Wills Date Cono 2806 Hildale Ave 2806 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) 7268 Devs 250 - 40 7261 Usuel Residence of Decedant 5. CANGINO my 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nos 2 No BALTIMORE Marylono 10e. Street and Number 2806 Hildale Ave 10f. Zip Code 10g. Citizen of Whet Country? 21215 15A 2806 01207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Wes Decedent Ever in U.S. 14. Raca - American Indian, Wes Decedent Ever III.
Arned Forces?
12 Yes 2 No Korean
14 Yes Give
Year or Dates: Countie Black, White, etc. 12 Never Married 2 Married 1□ Yes 2□No Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Varry 4. Stevenson Elamantary/Secondary (0-12) Collaga (1-4or 5+) 11th grade JANITOR 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Giooman, MABEL biorg &

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda 2 6020

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RUND

Altamont Place S.E.

forest let Con 222. Name end Address of Facility CUA THAN

50 40 REISTERSTULIN

WASHINGTON, D.C.

Approximate Intervel Between Onsat and Death

1 ☐ Yes 2 ☐ No

BALTIMORE, MD ZIZM.

4EAR<

20c. Location - City or Town, State

the Maryland "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death altimore, Maryland 21215-0020 other than Departman of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, I 2 should be f and Mental H Pages 1 and 2 s mant of Health an

Physician

/Medical

Examiner

10a. Stete

Directo

Funerai

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Completed

Be

2

19e. Informant's Name/Relationship (Type, Print)

LENA M. Grupman

21. Signeture of Funeral Servica Licania

Burlal 2 ☐ Cremetion 3 ☐ Removel from Stete
4 ☐ Donation 5 ☐ Other (Specify)

20a. Method of Disposition

Funeral

Director

Physician /Medicai Examiner

has this cartificate Aftert

The law requires that the death certificate be executed

or Attending Physician:

Hospital

To the

death.

Division of Vital Records, P.O. Box 68760,

23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediete Cause (Finel disease or condition resulting in daath) CANCER COLON Due to (or as e consequence of) Physiclan/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaese or injury Due to (or es a consequence of): thet Initieted events resulting in death) Lest Due to (or as e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to complation of cause of daeth? 24a. Wes an autopsy performed? Completed 1 Yes 2 No Be 25. Wes casa referred to medical examinar? 26. Piece of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) P 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Pleca of tnjury - At home, farm, straet, fectory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1/2 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as statad. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and mennar stated. 29c. License number 29d. Date signed (Month, Day, Year)

SISTER

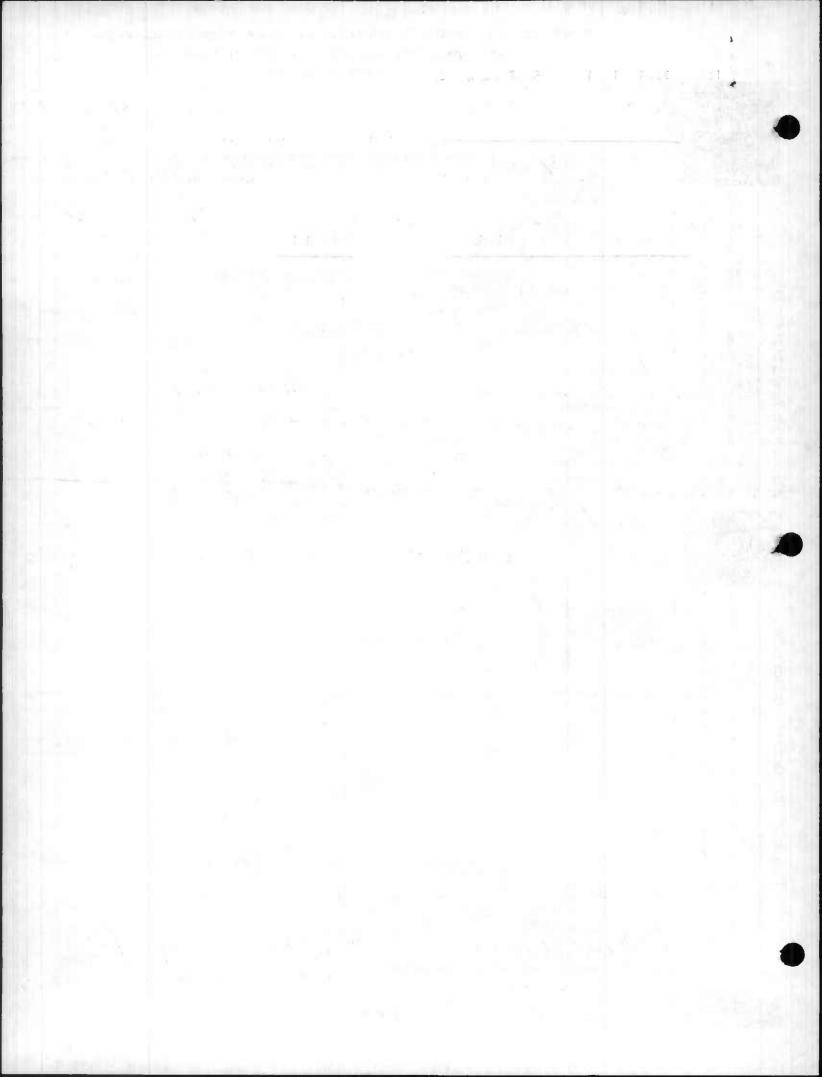
2321 20b. Placa of Disposition (Name of

cametery, crematory or other place)

State Registrar

GREENE ST, 10 N

person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** Day Robert 8.06 PM Gladden February LST 1996 action of Death 45. County of Death 1ST 1998 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7. Age (Ill yrs. lest birthday) Baltimore
if Under 24 Hrs. 8. Date of Bir our NIA 8. Date of Birth (Month, Day, Year)
Oct. 16,1962 if Under 1 Year 6. Sex 1 M 2 ☐ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months 219-74-800 Hours Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 1 Yes 2 No Item 27 is marked other than "natural", or Items 23s or 28s-1 st other traumetic event, tre Moorest Exeminer must be not lised Funeral Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? hown 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status Race - Americen Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "nature". ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Black Specify: Completed by Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)

Grade

17. Father's Name (First, Middle, Lest) Cotlege (1-4or 5+) aborer Tisina 18. Mother's Name (First, Middle, Maiden Sumeme) Be A. sladden Wilhelmina 2 Kober Domas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Thoun Street Battimore, Mary knows 2002. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State butus Memorial Park 2-6 Baltimore, 11 brylond 4 ☐ Donation 5 ☐ Other (Specify) -98 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph H. BROWN JR. Funeral Home, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heer failure. List only one cause on each line. Approximate Intervat Between Onset end Death Physician /Medical Encephalo pathy Immediate Ceuse (Final ZWKS disease or condition resulting in death) **Examiner** Physician/Medical Examiner Failure ZWKS or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): the bunial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 88 MONAry USB signed by the ette Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 24a. Was an autopsy performed? page 2 should 1 ☐ Yes 2 No certificate director, Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) examiner?
1 Yes 2N No
27. Manner of Death
1 Natural 5
2 Accident Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Date of Injury
(Month, Day Year) 28b. Time of Injury
(Month, Day Year) 28c. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending investigation efter death. 1 ☐ Yes 2 No the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Biely (Check only one)

within 2 To the Complet

State Registrar 31. Date liled (Month, Dey, Year) FEB 0 3 19

29b. Signature end title of certifier

2600 Registres Signature Randa D

cause of death (Item 23a) (Type, Print)

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D38993

29c. License number

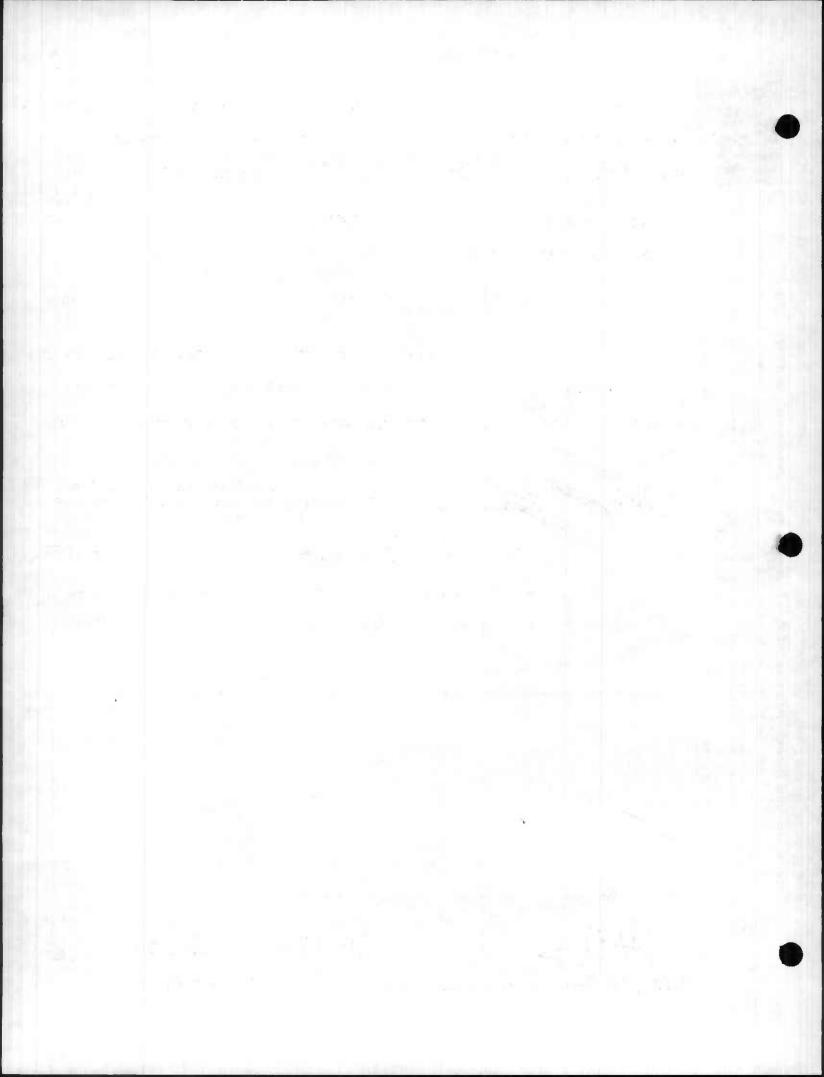
29d. Date signed (Month. Dev. Yeer)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Day 1998 **Physician** 20 PM JAN.27, RUTH GREENFIELD /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 6336 CEDAR LANE #350 COLUMBIA HOWARD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT.6,1913 Birthplece (Stete or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 F Deys Hours Yrs. Director 057-07-7971 84 NJ Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at Director 1 ☐ Yes 2 No COLUMBIA MD HOWARD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò #350 Items 23a 6336 CEDAR LANE 21044 Funeral U.S.A. filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0020 ò by 1 ☐ Yes 💥 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondery (0-12) College (1-4or 5+) ELEMENTARY TEACHER BALTO COUNTY SCHOOLS il Hygie 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Peges 1 end 2 should be nent of Heelth end Mentail h end Mentai h MICHAEL WARD REBECCA SHAPIRO 10 19e. tnforment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Heelth or Important: If item 27 is any injury or other trau once. MARILYN HANDWERGER / DAUGHTER 4237 BLUE BARROW RIDE ELLICOTT CITY, MD 21042 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Valurial 2 ☐ Cremetion Removel from Stete 1/30/98 COLUMBIA, MD ec(fy) OLUMBIA MEMORIAL PARK 21. Signature of Eur 22. Name end Address of Fecility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, the on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel WBEK diseese or condition resulting in death) Examiner Examiner JANANUCLEM The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Box 68760. ettending physician DB MENTSCUM 4000 Physician/Medicai Due to (or as e consequence of) ed by the el deteched for P.0. Pert II. Other stgniftcant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? s been signed by the should be detech 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by Division of Vital Records. 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? Completed 24a. Wes en autopsy performed? hes this certificete 1 TYes 2 No 1 ☐ Yes 2 ☐ No Attending Physicien: funeral director, 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home SE Hesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation Naturel death. 1 ☐ Yes 2 ☐ No spital or Attendi ours efter death-nerel Director: A filled in by the f 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Punerei 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29a. Certifier Médicai 29b. Signature of 29c. License number 29d. Date signed (Month, Dey, Yeer) of person who completed cause of deeth (Item 23e) (Type Rint) 10 31. Date filed (Month, Dey, 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Z 7 January 4c. County of Deeth THOMAS G. GRIFFIN 3:09 pm 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death UNION MEMORIAL HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN. 02, 1947 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ₩ 2 □ F Days Hours 220-50-3918 51 Yrs. MARYLAND Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND N/A BALTIMORE CITY 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 504 E. 21ST. STREET 21218 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Yeer or Dates: 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: NEGRO 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HT8 ODD JOBS PRIVATE HOMES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) CROWDER GRIFFIN ANNIE MAE WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE WILLIAMS / NIECE 504 E. 21ST STREET BALTO, MD. 21218 20a. Method of Disposition

1 □ Burial 2 □ Cremation 3 □ Removal Irom State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State MT. ZION CEMETERY FEB. 2, 1998 4 ☐ Donation 5 ☐ Other (Specify) BALTO, MD. 21. Signature of Funeral Service Libense 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause or each line. 21213 Approximete Interval Between Onset and Deeth HCUTE Renal Failure Immediate Cause (Final disease or condition resulting in death) ronic Renal Failure 34 cui Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Dilated cardio myopathy 1 Yes 2 No 3 Probably 4 Unknown HIV infection 24b. Were autopsy findings aveilable prior to 24e. Wes en autopsy performed? completion of cause of death? Recurrent Endocarditis ¥Ø Yes 2□ No 1 Yes 2M No Was case exemine? 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: →□ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 2₹. Manner of Death 28b. Time of 28d. Describe how Injury occurred Natural 5 Pending investigation

nomas Gaylord To the Hospital within 24 hours a To the Funeral C

Physician/Medical þ Completed Be Medical Certification: To

Physician

/Medicai

Examiner

Funerai

Director

28a-f show

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items 23a

natural', or

d 2 should be filed within it and Mental Hygiene.
7 Is marked other than "r

Department of Health ar Important: If Item 27 is any injury or other trau

Physician

/Medical Examiner

Peges 1

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

29a. Certifier (Check only one)

2 Accident

3 Sulcide

4 - Homicide

6 Could not be determined 🍽 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted.

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated.

31. Date liled (Month, Day, Year)

29c. License number

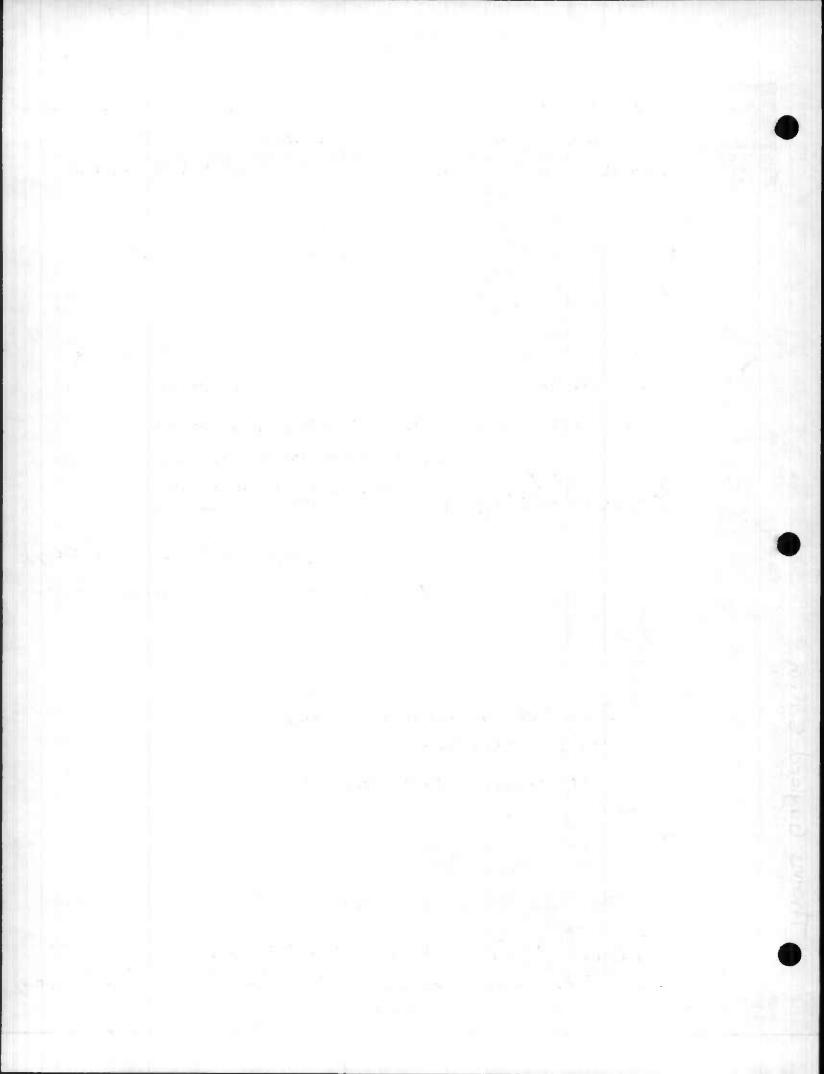
29d. Date signed (Month, Dey, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Pena

AT Z 438946 January Z7, 1998 Hosp. ZOI East Univasity, Par

State Registrar

Union memoria



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death GUARINO LEONARD :12 Am ebio 2-4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deal 4c. County of Death Calvert Manor Nursing Center Rising Sun ceci1 If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs, last birthday) Birthpiaca (Stata or Foraign Country) Months 1 M 2□F Yrs. 79 220 07 2703 May 28, 1918 Maryland Usual Residence of Dacedant 10b. County 10c. City, Town or Location 10d. insida City Limits Abingdon 1 Yas 2 No Maryland Harford 10e. Street and Number 10f. Zin Coda 10g. Citizen of What Country? 2805 Gray Antler Ct. 21009 United States Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar In U,S. Armed Forcas? 11. Marital Status 14. Race - Amarican Indian, 1X Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married 1 ☐ Yas 2 No Specify. Specify: White 3√ Widowed 4 Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Laborer Railroad 17. Fathar's Nama (First, Middla, Last) 18. Mothar'a Nama (First, Middla, Maidan Sumama) Anntionette (Unknown) Luigi Guarino 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2805 Gray Antler Ct., Abingdon, MD Annette M. Furlong / Daughter 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Buriai 2X Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) 2/3/98 Baltimore, MD Green Mount Crematory 22. Nama and Addrass of Facility CAFA Stephen D. Lohrmann P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Dr., Baltimore, MD 21286 Approximata Intarval Between Onset and Death Immediata Causa (Final disaasa or condition resulting in death) garz BSCVO Dua to (or as a consequance of): Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cimer 1 Yas 2 XNo 1 Yas 2 No 26. Place of Death (Check only ona)

Physician /Medical Examiner

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Division of Vital Records, P.O.

Examiner

Physician/Medicai

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Certification:

Medical

Physician

/Medical

Examiner

Director

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10a. Stata

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Hatilh and Mental Hygiene.
Important: If item 27 is marked other than "netural", or items 23s or 28s-1 show any injury or other traumatic event, in Medical Evandor mat be normal any injury or other traumatic event, in Medical Evandor mat be normal at

Saltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that leited events.) that Initiated evants rasulting in death) Last

25. Was casa rafarred to medical axaminar? 1 Yas 2 No

Hospital: Othar: 4 Nursing Homa 5 - Rasidance 8 - Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

27. Mannar of Death 1 Natural 2 Accident 3 Suicida 4 Homicida

28a. Data of Injury (Month, Day Year) 5 Panding Invastigation 6 Could not be datamined

30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

Taylor

1 Yas 2 No 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

🔀 Certifying Phyeician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

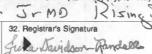
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29b. Signatura and titla of certifiar

29c. Licensa number

29d. Data signed (Month, Day, Year)

31. Data filed (Month, Day, Year)

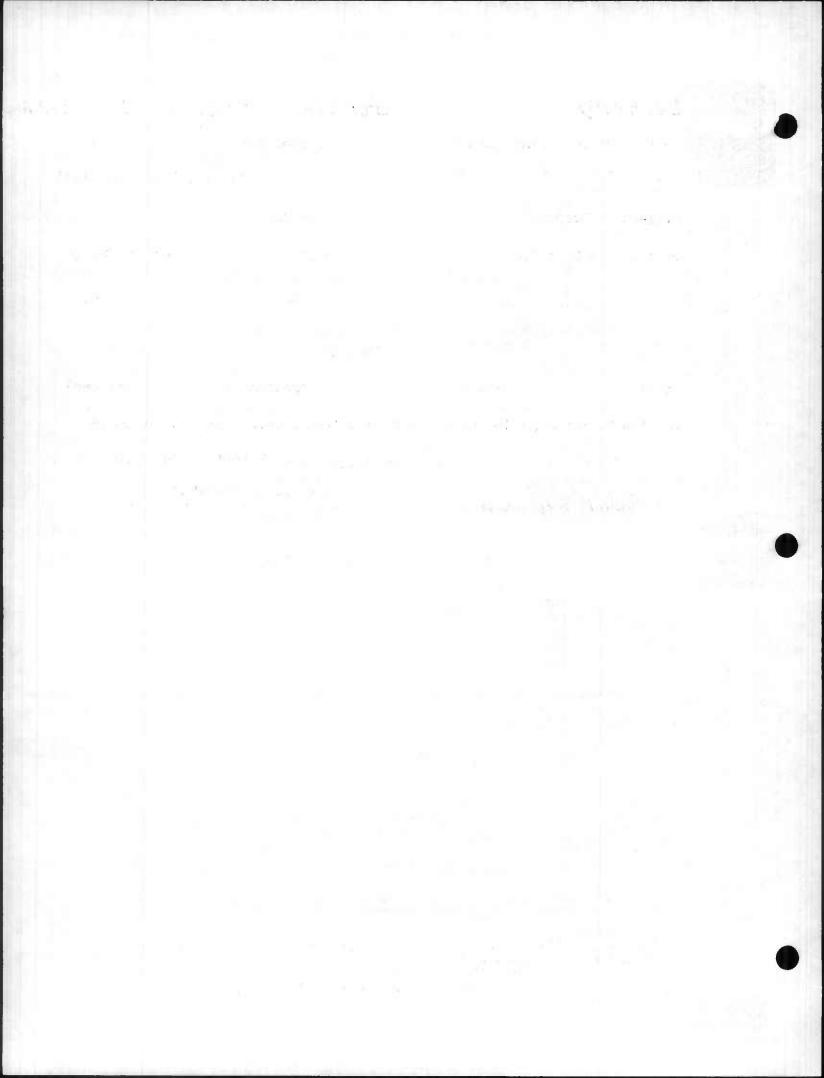


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DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** GINSBERG Z: 20 PM ALBERT JAN /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. | 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 113M 2□ F Months Hours Yrs. Director 102-16-8603 July 21, 1920 Bronx, New Yor Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits e filed within 72 hours efter death with the Maryle al Hygien Linder Une "netural", or Herns 23a or 28a-f show I other than "netural", or Herns 23a or 28a-f show Went, its Maries Examine man be noted at Yes 2 No Director Silver Spring Maryland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 U.S.A. 14801 Pennfield Circle, #401 Funeral Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2000 Specify: Specify: by 3 □Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Dacedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 7 Years Self Employed Lawyer traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) 12 should be fill h and Mental H ' is marked oth Be 10 Philip Ginsberg Rose Friedman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 st Depertment of Health and Important: If Item 27 is n any Injury or other traun 20904 Kathy Daitch, Daughter 13831 Leibig Road, Silver Spring, Maryland Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1/30/1998 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery Adelphi, Maryland 22. Name end Address of Facility 21. Signature of Funeral Service Licenses mc0544 STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 4.6 232 CARROLL STREET, NW, WASHINGTON, DC 20012 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaasa or injury Box 68760 99 Physician/Medical that initiated events resulting in death) Lest Due to (or es e consequence of) 50 950 jo 23b. Did tobacco use contributa to the causa of death? ed by the e Part II. Other elgorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. of Vital Records, P.O. signed by 1 | Yee 2 No 3 | Probably 4 | Unknown þ 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Wes casa rafarrad to madical examiner? 26. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) P 1 ☐ Yes 2 ☐ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannac of Death 28b. Time of 28c. Injury at Work? Certification: CO 1- Natural 5 Panding 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 - Homicida 1 Certifying Phyelcian: To the best of my knowledga, daath occurred at the time, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and addrass of person who comple (Month, Day, Year) State

DHMH 16 Rav 6/95

Registrar

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Goodwin, Evelyr

Physician

/Medical

Examiner

Director

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Wed cal Example must be not frequenced.

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama /First Middle Last 2. Date of Deeth 3. Time of Death Month 7:40 PM 4b. City, Town, or Location of Death EVELYN GOODWIN 30 4a. Facility Nama (If not institution, giva streat and number) 4c. County of Death STELLA MARIS @ MERCY HOSPITAL BALTIMORE N/Aif Undar 1 Yaar | if Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 10/28/13 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) Birthplaca (Stata or Foreign Country) 1□ M 2⊠ F Yrs. 217-20-8496 MARYLAND Usual Rasidanca of Dacadant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S. 14. Race - Amaricen Indien, Black, Whita, atc. 21206 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 🗓 No Specify: Specify: BLACK 15. Decedant's Education (Specify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC NOT KNOWN -0-HOMEMAKER 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Malden Sumema) HAZE MALLORY MARY PALMER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 4512 SHAMROCK AVE, -BALTIMORE, MD DELORES JOHNSON (DAUGHTER) 21206 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Steta 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Removel from Stata MT. ZION CEMETERY 2/5/98 BALTIMORE, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatur of Funaral Sarvice Licensi 22. Name end Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST.-BALTO.. 23a. Pert1. Entar tha disaasa, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or raspiretory errast, shock, or haart failure. List only one cause on each line. Immediate Ceuse (Final disaasa or condition rasulting In daath) 3 months Sequantially list conditions, if any, laading to immadiata cause. Enter Undarfying Cause (Disaasa or injury thet initiated avents rasulting in daath) Last Dua to (or as a consequence of): Dua to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to complation of causa of daath? 24a. Wes an autopsy parformed? 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical axaminer? 26. Placa of Daath Chack only ona Stelly Maris at Mercy Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) Hospice 1 Yas 2 No 28a. Data of Injury (Month, Day Year)

Physician /Medical Examiner iclan end burief-transit physician e

Examiner Physician/Medical

80 USB signed by the a

by Completed

27. Mannar of Death

1 Natural

2 Accidant 3 ☐ Suicida

4 Homicida

31. Data tilad (Month, Day, Year)

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P.O. Division of Vital Records. dieal Certification:

> State Registrar

15 Certifying Phyaician: To tha best of my knowledga, daath occurred at tha tima, data and pleca, and dua to tha causa(s) and mannar as stated. 9a. Cartifiar (Check only one) 2 Madicel Examinar: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of cartifiar

5 Pending Investigation

6 ☐ Could not be

mong

30. Nama and address of person who completed causa of daath (Item 23e) (Type, Print)

Ferno, mo 32. Ragistrar's Signatura

28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Deta signed (Month, Dey, Year)

February 2, 1998

21236

28b. Tima of

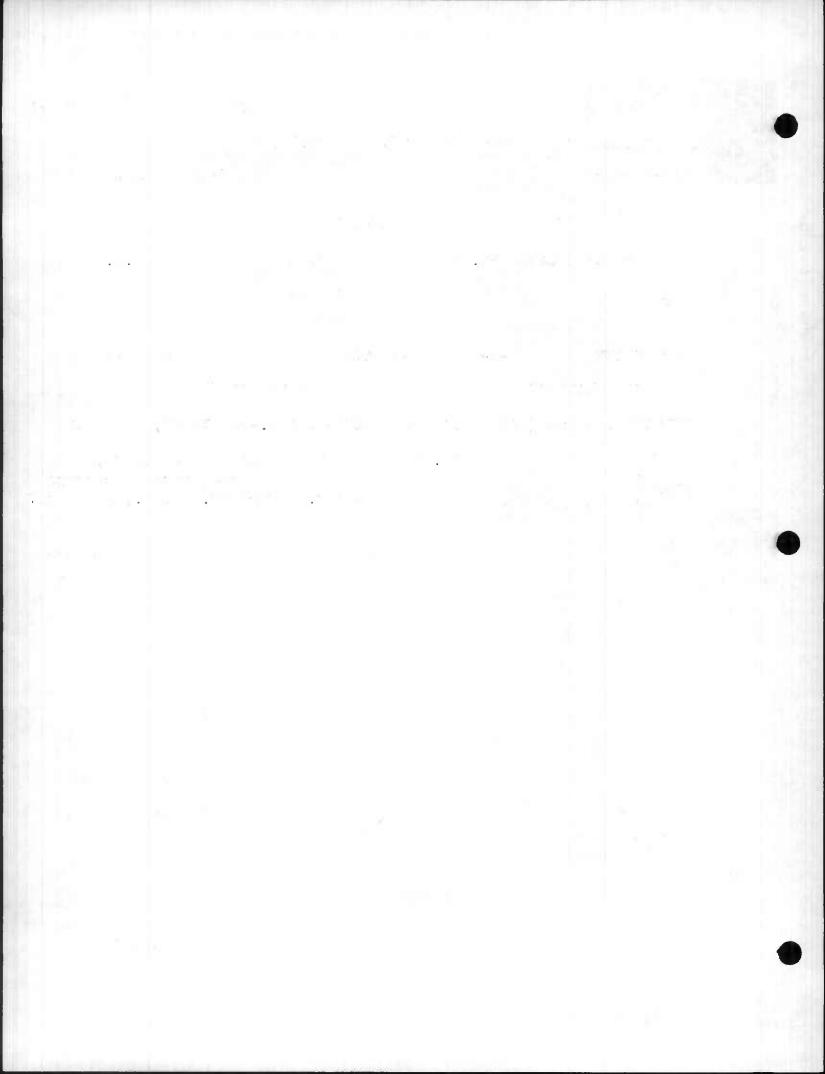
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28c. Injury at Work?

29c. Licansa number

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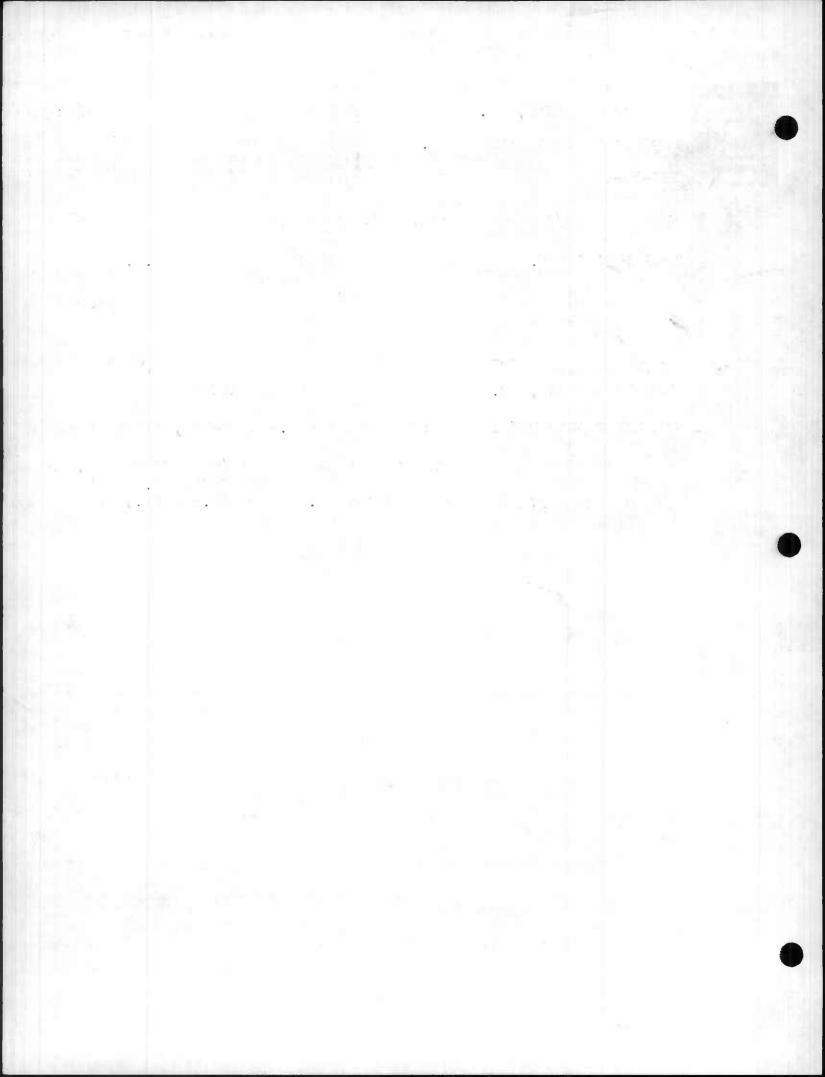
1 ☐ Yes 2 ☐ No



Division of Vital Records, P.O. Box 68760,

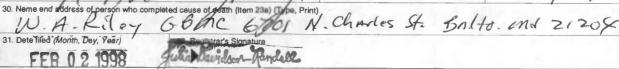
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	21. Signature	Funeral Service Lice	ensee /	· ·	22. Name	end Addre	ss of Facility	ELIZAB	ETH L.	PHILL	IPS	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Jamuary 29, 1998 10:50 PM Joseph S. A. Giardina /Medical 4e. Fecility Neme (If not institution, give streat and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner Keswick Mulit-Care Center Baltimore N/A | If Undar 1 Year | If Undar 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | NOV • 7 1908 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (Stata or Foreign **Funeral** Months 1⊠M 2□ F Marviand 218-36-8055 Director 89 Yrs Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic avent, the Medical Examiner must be notified at Catonsville Baltimore Director Maryland 1 ☐ Yes 2K No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 5 Apt. 3202 21228 USA 707 Maiden Choice Lane items 23s Funeral 72 hours after death 12. Wes Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indien, Bieck. White, etc. 1 □ Navar Married 2 N Married 1 Yas 2 No If Yes, Give Yeer or Detes: 6 White 1 Yes 2 No Specify: by Specify 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withle Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than any injury or other trainment Elementery/Secondery (0-12) College (1-4or 5+) Public Service Comm. Director of Transportation Maryland 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surneme) Be Salvatore Giardina Josephine Fertitta 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21228 Mrs. Marie J. Giardina (Wife) 707 Maiden Choice Lane Apt. 3202 Catonsville, Md. 20b. Plece of Disposition (Neme of cematary, cremetory or other place) 20e. Method of Disposition Dete 20c. Locetion - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5夕Othar (Specify) New Cathedral Cemetery 2/2/1998 Baltimore Maryland 4 Donetion eral Servicettide 22. Neme end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Road KO. Make Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final phermonia 1 dA diseese or condition resulting in deeth) **Examiner** The law requires that the death certificets be executed Sequentially list conditions, if eny, leeding to immediate ceusa. Enter Undarlying Cause (Diseese or Injury that initieted events rasulting in deeth) Lest Due to (or es e consequence of) Box 68760. attanding physician for usa es the burie Physician/Medical Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by I Dernentin 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Multi- intavet A Completed 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Was an autopsy ate has 1 ☐ Yas 2 No certificate 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of Injury (Month, Day Year) Diractor: After the 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division Attending 1 Naturei 5 Pending Investigation death. 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, deta and piece, end due to the ceusa(s) and menner stated. Medical 29a. Certifier 29b. Signetura and title of benifier 29c. Licansa number 29d. Data signed (Month, Day, Year) aleg: 100 DZ520S

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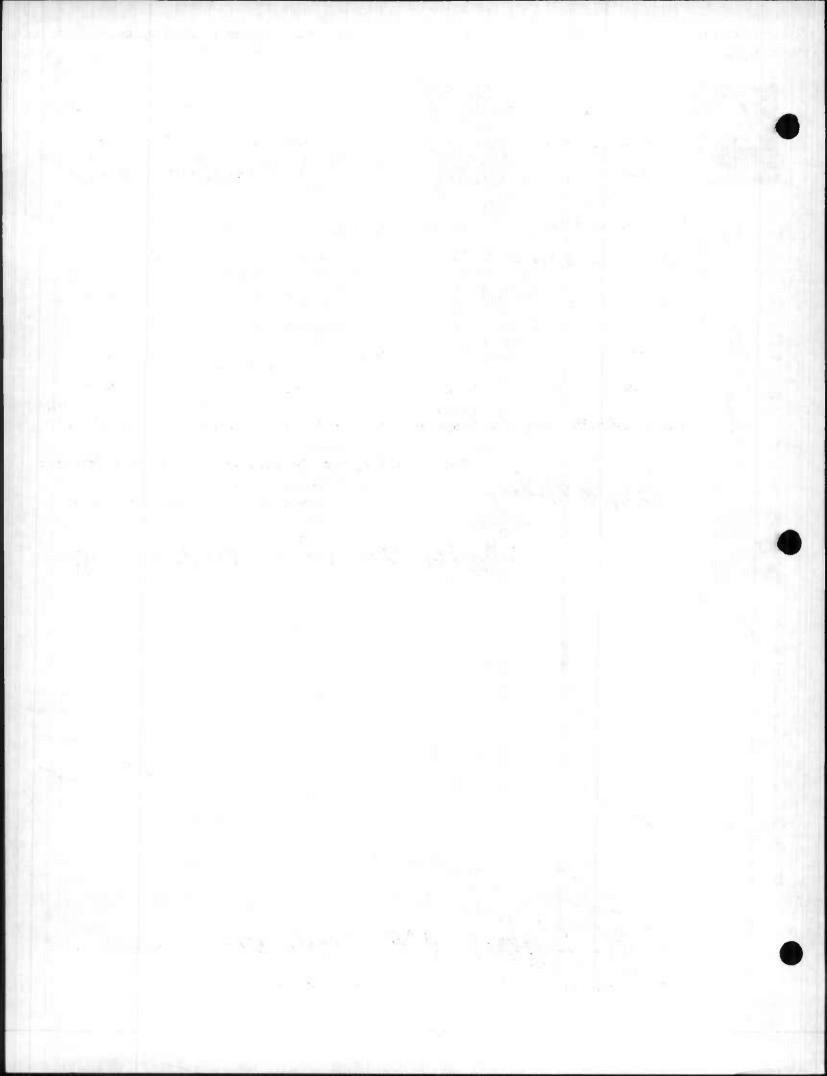
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State of Maryland / Department of Health and Mental Hydiene

			Otate of Mary		•	of Death	, ,	eg. No. 9 8	02958	3
	Dhualaian	1. Decedent's Name (First, Middle,	Last)				2. Date of Deat Month		3. Tima o	f Death
	Physician /Medical		RNARDINE HE	YL			NUARY	31 1	998 12:3	Ø PM
	Examiner	4a Fecility Nama (If not institution, Saint Joseph		nter		4b. City, Town, or Loc		4c. County	of Death altimore	
ľ	Funeral Director	5. Social Security Number 219–58–7005		yrs. last birthda Yrs.	Months	Year If Under 24 Hrs. Days Hours Min.	8. Dale of Birth (Month, Dey October 4	Year) , 1912	9. Birthplace (State Country) Maryland	or Foreign
	and	Usual Residence of Decedent 10a. State 10b. County	100	City, Town or	Location				10d. Inside C	Ity Limits
	Meny Hehr	Maryland Bal	timore	Tim	onium				1 □ Yes	XX No
	vith the Me or 28s-fe be notified Director	10e. Street and Number	0211101 0		10f. Zip C	Code	1	0g. Citizen of V	/hat Country?	M
	ath wi	2300 Dulaney Val				21093		USA		
21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a4 show any injury or other traumatic event, the Medical Examinar must be northed an once. To Be Completed by Funeral Director	11. Marital Status 1 Nevar Married 2 Marrie 3 WWidowed 4 Divorcad	12. Was Decedent Ever Armed Forces? 1 Yes XX No If Yes, Giva Year or Dates:	In U,S.	3. Was Decede If Yes, specif 1☐ Yes X2	nt of Hispanlc Origin? (Specy Cuban, Mexican, Puerto F XNo Specify:	cify Yes or No- lican, etc.)		e - American Indian, k, White, etc. : White	
15-0	natur olcal	15. Decedent's (Specify only highest		16a. Da	cedant's Usual	Occupation done during most of workin ratired)	g	16b. Kind of Bu	siness/Industry	
121	within ene. than he we	Elementary/Secondary (0-12)	Collega (1-4or 5+)		emaker	ratired)	-	Ours U	omo	
	Mental Hygiene. Mental Hygiene. Metric event, the Matic event, the M	17. Father's Name (First, Middle, La	st)	11011	lelliakei	18. Molher's Name	(First, Middle, I	Own H		
ylar	Mental H Mental H Merked oth ratic even	John Roddy				Isabel F	ulton			
Maryland	2 sho lend lis ma raum	19a. Informant's Name/Relationship				Street and Number or Rural				
	1 end Health am 27 ther tr	Charles Roddy He				Manor Court			City or Town, Stete	
Baltimore,	eges ant of t: If its y or o	Burlal 2 Cremation 3 Donetion 5 Other (Spe	Hemoval from State		sposition (Neme remetory or oth	etery Hydes 2				
altir	Department Department Important: I any Injury o	21. Signature of Funeral Service Li		36 001111		Address of Fecility				
Ö	Depa Impo any li	Nounin de	Am XPMO	k	6500 Vo	ork Road Balt			edefeld Ho	me
Г		23a. Part1. Entar the disease, of cashock, or heart failure. List or	implications that caused the	death. Do not	enter the mode	of dying, such as cardiac or	respiratory arr	esi,	Approxima Interval Be	tween
ŧ.	Physician /Medical	The second secon							Onset and	
	Examiner	Immediate Cause (Final disease or condition resulting in death)	MYOCARDII		ARCTIC	JIN			10 DA	IYS
	je literal		Dua	to (or as a con:	sequanca of):					
	death certificate be executed eatherding physician and of for use as the bunlet-transit sician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underwing.								
60,	be exe cian e buriel-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C							
68760,	g physicia as the bur Tedical	that initiated events resulting in death) Last	Due	o (or as a cons	sequenca of):					
Box	nding use a		d							
	es that the death certification by the attending be deteched for use a by Physician/M	Part II. Other significant conditions	contributing to death but no	resulting in the	e underlying cau	use given In Part I.	given In Part I. 23b. Dld tobacco use co			of death?
P.0	requires that the nean signed by the hould be deteched by Physelect By Physelect by Physelect By	SEPSIS					1 jax	es 2 No	3 Probably 4] Unknown
	be d	БПГБТБ					04-14		24b. Were autopsy	findings
Records,		CONGESTI	VE HEART FA	LILURE			24a. Was a perform	med?	eveilable prior completion of death?	10
Rec	hes ye 2						1 D Y	es 2 No		No
Vital	certificate rector, pag	25. Was casa raferred to medical				26. Place of Death			1 1 1 1 2 4	
of V	2 00	examiner? 1 Yes 28 No		2 □ ER/Outpa			ne 5 🗆 Reside	ence 6 🗆 Oth	er (Specify)	
o uc	After thunera	27. Manner of Death 1 C Natural 5 Pending	28a. Data of Injury (Month, Day Yea	28b. Time Injur		Work?	8d. Describe h	ow injury occur	red	
Division	Attending or death. ector: After by the fune iffication	2 Accident investiga 3 Sulcide 6 Could no	be con Disease (Indiana	At home, farm.	M street, factory.	1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Routa Number,			
Div	tal or Attending P rs effer death. at Director: After t led in by the funer; Certification:	4 ☐ Homicida datermin	building, etc. (St	ecify)	otroot, tuotory,		City or Tow			
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: T	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my aminer: On the basis of examend manner stated.	knowledga, da nination and/or	eath occurred at investigation, is	the tima, data and place, a n my opinion, death occurre	nd due to the c d at tha time, d	ause(s) and ma ata and placa,	inner as stated. and due to the cause	(s)
	withir comp	29b. Signature and little of confine	D		29c.	License number	2	29d. Date signed (Month, Dey, Year)		
		411/2	-		D46	6652		1-3	1-98	
	6	30. Name and addrass of person wi								
		KEVIN DONAHUE. 31. Date filed (Month, Day, Year)			K ROAI	, TOWSON,	MARYL	AND 2	1204	
	State Registrar	FFB 0.3 19	32. Flegistrar's 8	udson-R	male					

DHMH 16 Rev 6/95

HOLDROSEL ANDROUSE

THE PERSON NAMED IN

THE PROPERTY AND ADDRESS OF THE PROPERTY OF TH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month HOOK Wade January 9:51 27 1998 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Johns Hopkins Hospital Baltimore N/A 8. Date of Birth (Month, Dey, Yeer) Oct. 15, 1922 South Carolina 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 1 M 2□ F Months Deys 75 Yrs. 251-16-0419 Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Pennsylvania Adams Gettysburg 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 195 Ridgewood Drive 17325 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 25 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorcad White Year or Dates: WW2 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Professor Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mary Ann Dreher Sandel 1 Walter Hook 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) (Wife) 195 Ridgewood Drive, Gettysburg, PA 17325 Melverda Padget Hook 20a. Method of Disposition 20b. Ptece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) West Columbia, SC Mt. Hermon Cemetery 2/2/98 Martin D. Lawson 22. Name end Address of Fecility 21. Signatur Mitchell-Wiedefeld Home Martin D. 6500 York Road, Baltimore, Maryland 21212

Approximete Intervel Between Onset end Deeth 23a. Pert1. Enter the diseese, or complications that caused the death. Do not shock, or heart feilure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in death) lyear T-cell lymphoma Due to (or es e consequenca of): Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequence of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No

Examiner certificata be axecuted Box 68760, physicien tha usa as ettending | P.O. I the Š signed b Records, pege 2 certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i

Examiner Physician/Medical þ Completed Be Lo Certification: Medicai

Physician

/Medical

Examiner

Funeral

Director

28a-f show

or items 23s or

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Hygiene.

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis important: If Item 27 is marked other 1 any Injury or other treumatic event.

Physician

/Medical

72 hours efter

altimore, Maryland 21215-0020

the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be 2

State

Registrar

29b. Signetive end title of cartifier Huary DU (12

nouse officer

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number RES-000

Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the cause(s) end manner stated. 29d. Dete signed (Month, Dey, Year) January 27, 1998

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Johnstoplans MD

Hospital, Baltimon, Maryland 21287

31. Dete filed (Month, Day, Year)

3 Suicide

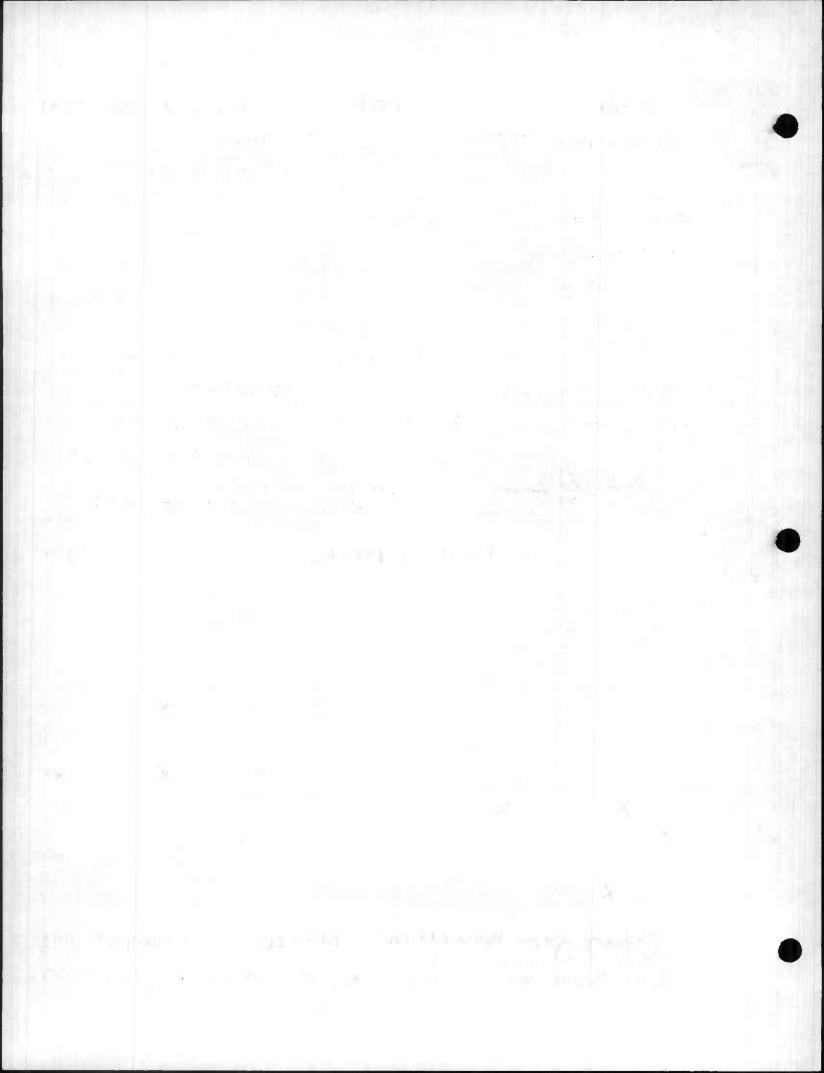
29a. Certifier

4 Homicide

6 Coutd not be determined

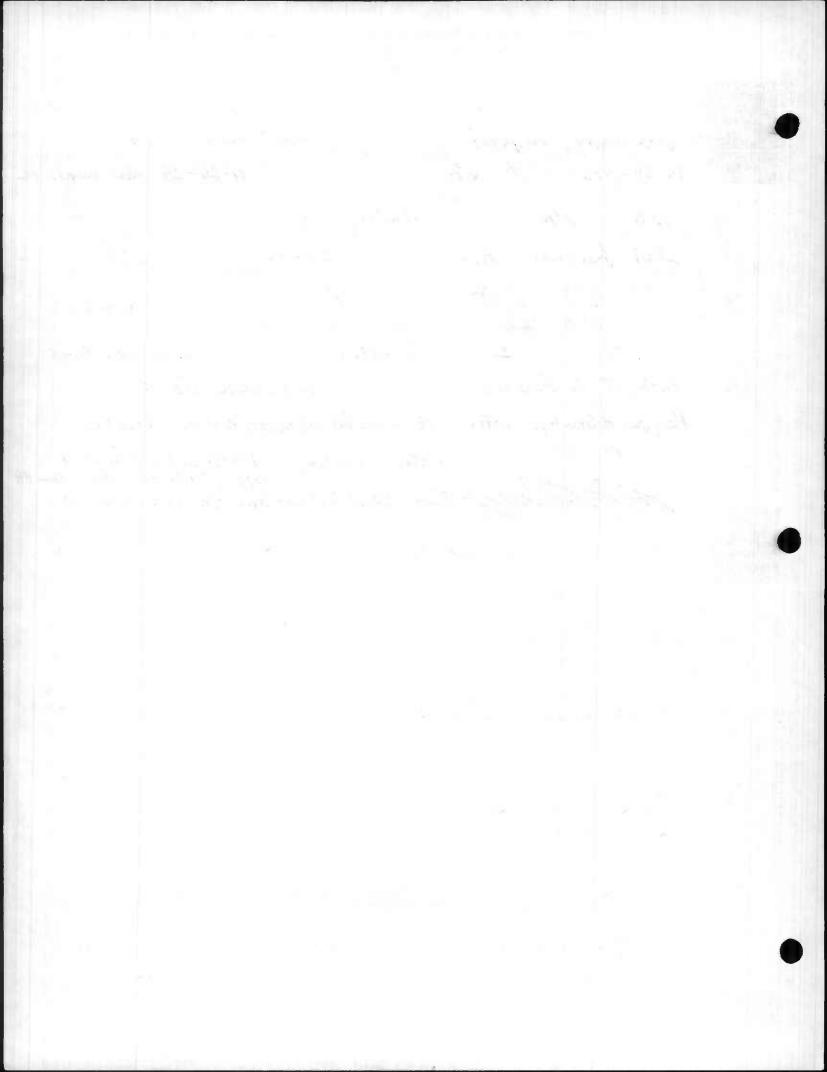


DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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Funeral		5. Social Sacurity Number 6. S	Sax 7. Ag	e (In yrs. last birti	hday) If Und Month	ler 1 Year s Deys	If Undar 24 Hrs. Hours Min.	8. Date of Bir	th V Voerl	9. Birthplace	Stata or Fo
Director		216 - 26 - 1432 Usual Residence of Decedent	□ M 20945	68	rs.	Deys	Hours Mill.	8. Date of Bir (Month, Da	-29	Weis He	mpsh
wo #		10a. State 10b. County		10c. City, Town						10d.	Inside City Li
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or 28	Funeral Director	10e. Street and Number				ip Code			10g. Citizen of \	What Country?)
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ene. than "natural", or items 23a or 28a-f show re Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 V If Yes, Giva Year or Dates:	No		2546	Specify:	o ritodii, etc.)	Specify		te
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f Health Item 27 other t		20a. Method of Disposition		20b. Place of	Disposition (A	ama of		Date	20c. Location -	City or Town,	Steta
0=5		1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from Stata			otnar plac		1.2: 00	R.T.	11	110
ortant: Injury		21. Signatura of Funeral Sarvice Licar		MET		Concel C	ss of Facility	1-31-98	CALIGORIS	Ville	11).
Departm Importal any Inju		LT. Signature of the order of t	57	-	22. 140//10	arid Addres		1/berT			
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		Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d tha daath. Do n ne.	ot enter the m	ode of dyin	g, such as cerdiad	or respiratory a	rrest,	Ap Int	proximate erval Betwee
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Medicai kaminer		Immediate Cause (Final disease or condition	, me	sente	ne	150	hemiz			7	24 h
· carrinici		resulting in death)		Due to (or as a c	onsequence o	f):					
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orial urial		Sequentially list conditions, if eny, leading to Immediate cause. Enter Undarlying Cause (Disease or injury that Initiated events	C							1	
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State of Maryland / Department of Health and Mental Hygierie

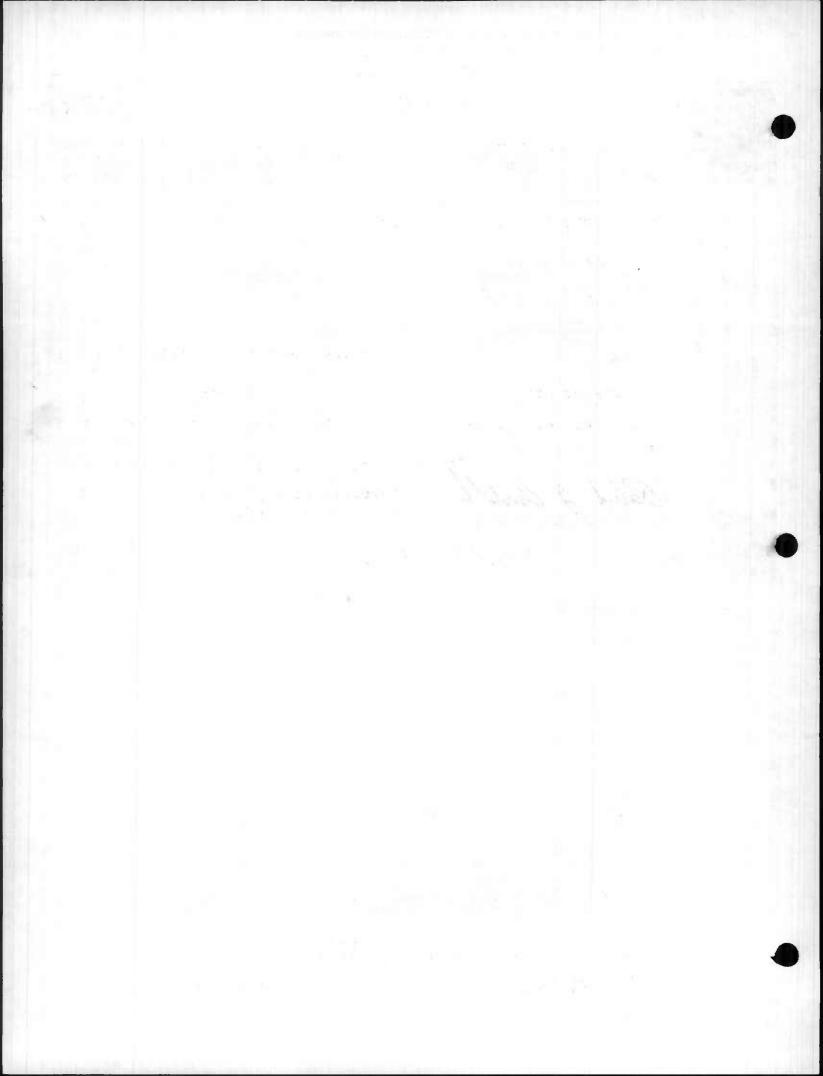
Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Tima of Deeth **Physician** Month Yaer 12:29 AM Lovetta Howard 1998 January 29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth **Examiner** Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 6 Sax **Funeral** Birthplaca (State or Foreign Country) Days 1□ M 2 F 242 44 6085 73 Yrs Director Canada Usual Rasidence of Dacadant death with the Maryland 10a Stata 10h County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Baltimore Maryland Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23s or 7804 St. Clair Lane 21222 U.S.A. Raca - American Indian, Bleck, Whita, atc. 12. Wes Dacadant Ever In U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yas, Giva Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) filed within 72 hours efter 1 Navar Married 2 Marriad 21215-0020 White 1 ☐ Yas 2 ☒ No Specify: þ 3 Widowad 4 Divorcad "natural" Completed 16a. Dacadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry nd Mentel Hygiene. marked other than Elamantary/Secondary (0-12) Collaga (1-4or 5+) Scaleman 10 Steel Mill Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mentel H lant: If item 27 is marked out Be Elmer E. Mease Elsie L. McCormick other traumatic 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2: Department of Health ar Important: If Item 27 is any Injury or other trau Eddie E. Howard (Son) 1947 Sunberry Rd. Baltimore, Md. 21222-4652 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Moreland Memorial Park 1/31/1998 Baltimore, Co. Md. 22. Nama and Address of Facility 21. Sign Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 disaasa, or complications that causad tha death. Do not antar the mode of dying, such es cardiac or respiretory errast, failure. List only ona cause on each lina. Approximata Interval Batween Onsat and Death Physician /Medical Immadiata Cause (Finel Acute myocardial disaase or condition resulting in death) **Examiner** Dua to (or as a consaquanca of) Examiner The law requires that the death certificate be executed Sequantially list conditions, if eny, laading to immadiata causa. Enter Undarlying Ceuse (Diseasa or injury that initiated events rasulting in daeth) Lest and the buriel-tran Dua to (or es e consequança of): Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to daeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 signed by th 1 Yes 2 No 3 Probably 4 Tunknown by 24b. Wara autopsy findings eveilable prior to complation of cause of death? pege 2 should Completed 24a. Was an autopsy peen this certificate has 1 X Yes 2 No 1 Yes 2 No Attending Physician: director, Be 25. Was casa rafarrad to medical 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yas 2 No 1 Sinpatiant 2 □ ER/Outpatient 3 □ DOA Certification: 28c. injury at Work? 27. Mannar of Daeth 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred After 5 Panding invastigation 1 **S**Naturai 1 ☐ Yas 2 ☐ No death filled in by the f 2 Accidant 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 D Homicida 0 To the Hospital within 24 hours a To the Funeral Completely filled edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta end plece, end due to the ceuse(s) end menner es stetad.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred et tha time, deta and placa, and dua to the ceusa(s) and manner statad. 29a. Cartifiar 29b. Signatura end titla of cartifiar 29c. License number 29d. Data signed (Month, Dey, Yeer) 96000 29,1998 January 30. Nama and eddrass of person who complated causa of death (item 23a) (Type, Print) Baldanza lodd 4940 Eastern Avenue Baltimore 31. Data filed (Month. Day, Year) 32. Registrar's Signatura State 3 1998 he javidson-Mandell FEB Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1000			State of Mary		rtificate of		, ,	ng. No. 9	02962	
Physicia /Medic		1. Decedant's Nama (First, Middla, Las	te	eMin6			2. Deta of Death Month JAN	Day 29	Yaar 3. Tima of 0	Death PM
Examin	er	4a. Fecility Nama (If not institution, give				4b. City, Town, or Lo	ocation of Death	4c. County	of Death Arundel	
Funeral Director		Social Security Number 6. Security Number		yrs. last birthday) Yrs.	If Undar 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, May 1	Year)	9. Birthplaca (Stata or Country) 5. Albany,	Foreign NY
death with the Maryland ms 23s or 28s-f show r man be notified at		10a. Stata 10b. County	100	c. City, Town or Lo	cation				10d. Insida City	y Limits
tha Mar	ecto	MD Anne A	rundel	Odento					1 □ Yas	2 No
with the or 2	- D	10e. Street and Number			10f. Zip Coda		10	0g. Citizan of V	Vhat Country?	
P 5 2	by Funeral Director	530 Saltoun A 11. Marital Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced	Venue 12. Was Decedant Evar Armed Forcas? 1 ☐ Yas 2 ☑ № o If Yas, Giva Yaar or Detes:		211 Was Dacedant of H f Yes, specify Cub	13 lispanic Origin? (Speen, Maxican, Puarto Specify:	ecify Yas or No- Rican, atc.)	14. Rac Bled	USA e - Amarican Indian, ck, Whita, atc. White	
21215-0020 d within 72 hours after giena. "natural", or ite r than "natural", or ite	Completed	15. Decedant's Ed (Specify only highest gred Elamantary/Secondary (0-12)	ucation fa complatad) Coilaga (1-4or 5+)	16a. Deced (Giva lifa. L	fant's Usual Occup kind of work dona DO NOT usa ratired	eation during most of work d)	ing	16b. Kind of Bu	usinass/Industry	
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Maryland 2 to 2 should be filed the and Mental Hygi if is marked other treumatic event, is	Be	17. Father's Nema (First, Middla, Last)				18. Mother's Neme	e (First, Middla, N	faidan Sumen	a) Insuran	ce
Marylan 12 should be 12 should be 13 and Mental 15 merked treumatic ev	2	Dwight W 19e. Informant's Name/Ralationship (7)		19b. Malilr	ng Address (Street	and Number or Run	orothy	Lee City or Town	Stata, Zin Coda)	
Malth ar alth ar treu		Raymond E. He		_		oun Ave.		-		
Baltimore, Maryland semit. Pages 1 and 2 should be filed Department of Health and Mental Hymportant: if Item 27 is merked other my injury or other treumetic event, once.		20a. Mathod of Disposition 1 burial 2 Cramation 3 4 Donation 5 Other (Spacify	Ramovai from State	Ob. Placa of Dispo cemetary, cran	sition (Nama of natory or other plac	ce)	Data 2/2/98	20c. Location -	City or Town, Stata	
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Lammer	- G	rasulting in death)		to (or es a conseq						.12
Secuted al-transit	Examiner	Sequantially list conditions, if any, leading to immediate	b. Due	to (or as a consaq	uence of):					
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.O. Box the death cart by the attending	Physician/M	Part II. Other significant conditions co	ntributing to daath but no	t rasulting in tha u	nderlying causa giv	an in Part I.	23b. Did to	becco use co	ntribute to the causa of	death?
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(I) 00 00 (I)	Completed by						24a. Wes ar perform	n autopsy nad?	24b. Wera autopsy fin available prior to completion of car of death?	
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Division of the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicida 6 Could not be determined	28a. Place of Injury - building, atc. (Sp		28f. Location (Str City or Town		er or Rural Routa Numb	er,		
Hospitus Tarana	edicai 0	29a. Certifier Check only one) Cartifying Phy	alcien: To the best of my nar: On tha basis of exar and mannar stated.	knowledge, death mination and/or Inv	occurrad at the tir restigation, in my o	na, data and place, pinion, daath occurr	end dua to tha ca ed et the time, da	use(s) end ma ita and piace,	nnar as stated. and dua to tha causa(s)	
To the within To the comp	W	29b. Signature end titia of certifier	Mari	li.	29c. Licens	e numbar	29	d. Date signer	d (Month, Day, Year)	
5		30. Name and abdress okperson who o	ompleted causa of death	(Itam 23a) (Type,	Print)	Och Lim	ole MA	لرمهل م	21227	
Stat Registra		31. Dete filed (Month, Day, Year) FEB 0 3 1998	32. Registrer's S	Signatura Andrews	21/444	12~11W	AL ALL	n 4 mic	010.01	

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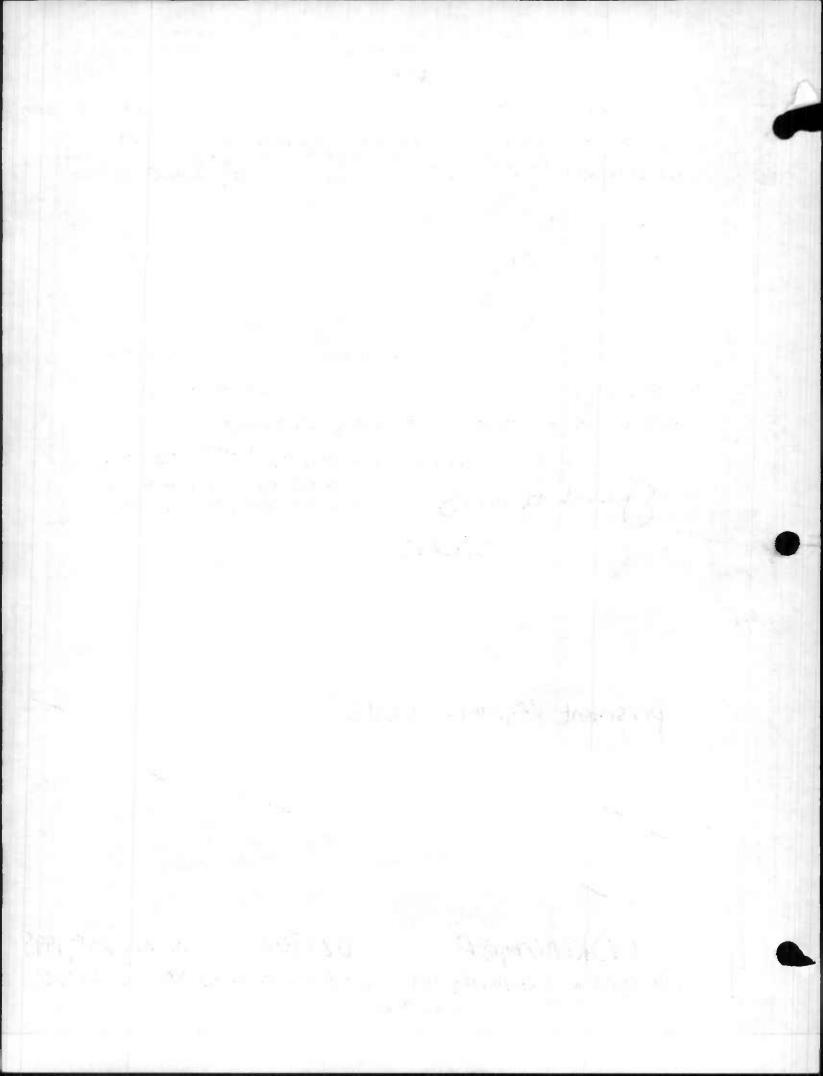


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Beuckly Johnson an. -10an /Medical 4e. Facility Name (If not astitution, give street and number, 4b. City, Town, or Location of Death **Examiner** Subacust Unit Hospital SECOR Bultimore City If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Days | Hours | Min. | Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F Director 212-28-8050 Maryland Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 No 2 No Director N/A Md. Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21223 300 S. Stricker St. USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes ≥ 27 No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: white by 3 ☐ Widowed 4 ☐ Divorced Specify Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementery/Secondary (0-12) College (1-4or 5+) 12 Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Schulz Ethel Virginia Granger 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Dunkerly - daughter P. O. Box 1126, Pasadena, Md. 21123 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/31/98 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Elkridge, Md. Meadowridge Memorial Pk. 21. Signatum of Funerel Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and feilure. List only one cause on each line. **Physician** Immediete Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): ă Part II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ pg Completed 24b. Were eutopsy findings evalleble prior to 24a. Wes an autopsy completion of cause of deeth? page 2 No 1 ☐ Yes 2 ☐ No certific Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Inversing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 10 Ź 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Certification: Athar 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident after death Director: / 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es steled.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29e. Certifier 29c. License number 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) D27860 death (Item 23e) (Type, Print)
NEY MD 700 WASHINGTON BIVD BAUTIND 21230

DHMH 16 Rev 6/95

State Registrar



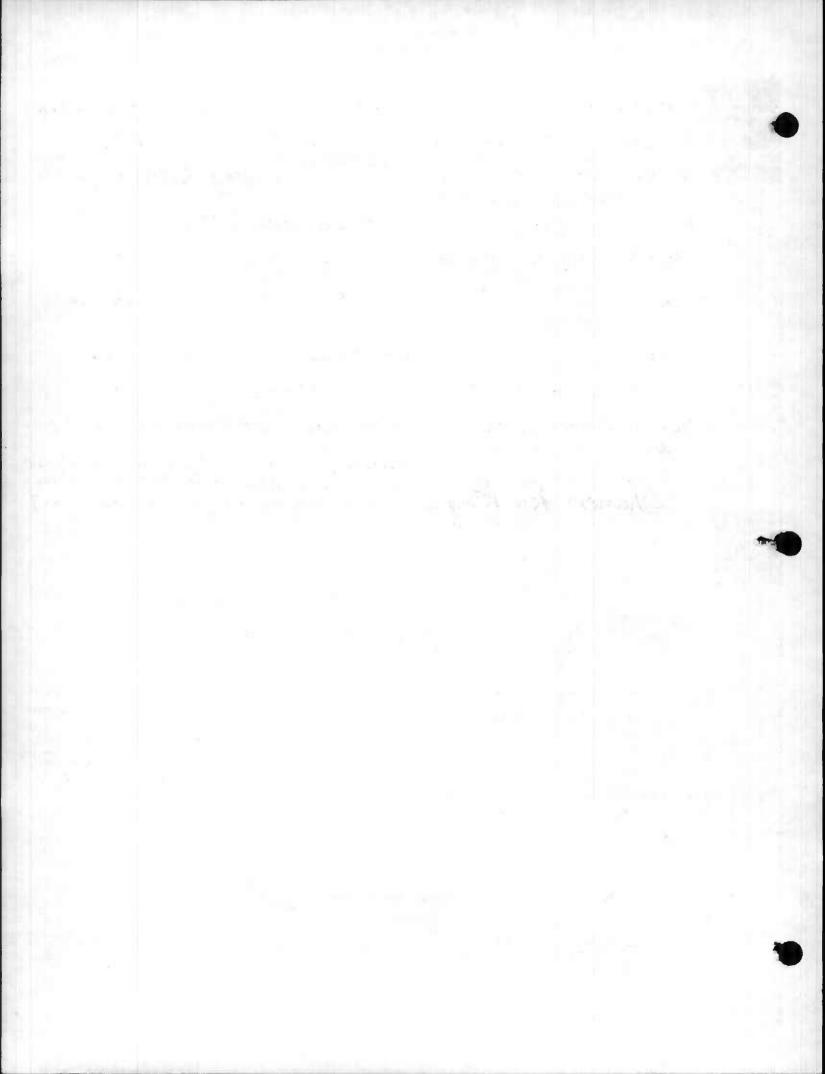
State of Maryland / Department of Health and Mental Hygiene \ \(\)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 29, 1998 **Physician** PATRICIA JOHNSON 12:01 Am /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Yaar Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 49 1□ M 2 F Hours MARCH 02, 1948 MARYL 215-52-0264 Director Usual Residence of Deceden 10a. State 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Yes 2□No Director BALTIHORE NIA MARYLAND 10e. Street and Number 1g. Citizen of What Country? 3683 Funeral KENYON AVENUE USA, 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 21215-0020 1 Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Specify: BLACK Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RESTAURANT GED WAITRESS Pages 1 end 2 should be filed w thent of Health and Mental Hygie Tant: If Item 27 Is marked other it jury or other traumatic event, In Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES FLETCHER SR. TEMPY LOGAN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: if Item 27 Is any Injury or other trait DAUGHTER) 58 BARNACLE COURT ESSEX MD, 2/22/
20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State DONIA JOHNSON altimore, 20a. Method of Disposition

1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL (EMETERY 02-02-98 WOODLAWN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee orkins 2140 N. FULTON AVE. BALTIMORE, MD. 21217 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final ARRHYTHMIA HULLR disease or condition resulting in death) Examiner Due to (or as a consequence of): MYOCARDIAL INFARCTION HOURS The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate causa. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Box 68760. DILATED CARDIONYOPATHY 15 YEARS Physician/Medicai the Due to (or as a consequence of) P.O. P Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown DNTAVENOUS DRUG USE Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy 1 Yes 1 ☐ Yes 💥 No Vital Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No of this the funeral 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? Division 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 Could not be determined 3 Suicide in by t 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde 6 Hospital 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number JANUARY 29, 1998 4940 EASTERN AVENUE 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOHNS HOPKINS BAYVUEW SMADIA ALIZAI, MM BALTIMORE, MD Z1224 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 3 1998

Registrar



19a. Informent's Name/Reletionship (Type, Print) daughter 19b. Malling Address (Street and Number or Fural Route Number, City or Town, Stete, Zip Code) 380 5 Bonner Road Baltimore, Md. 21216	George Jones 19a. Informent's Name/Relationship (Type, Print) daughter Genevieve Matthews 20e. Method of Disposition Burial 2 Cremation 3 Removel from Stata Donation 5 Other (Specify) 21. Signeture of Funeral Service Licensea 22. Name and Address of Fecility Nutter 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or resulting in death) Physician Medical Examiner Physician Medical Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying ause. Enter Unde	pute Number, City or Town, State, Zip Code) re, Md. 21216 late 20c. Location - City or Town, State 2 Baltimore, Md. er Funeral Homes, Inc.
Cenevieve Matthews 3805 Bonner Road Baltimore, Md. 21216	Genevieve Matthews 20e. Method of Disposition Description Descript	re, Md. 21216 20c. Location - City or Town, State 2 Baltimore, Md. er Funeral Homes, Inc.
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28e. Place of Injury - At home, farm, street, factory, office determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifiar (Check only one) 29a. Certifiar (Check only one) 29b. Signature and title of certifiar 29c. Licansa number 29c. Licansa number 29d. Data signed (Month. Day, Year)	determined 28e. Place of Injury - At home, farm, street, factory, office 28f	performed? aveileble prior to completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No heck only one) 5 Residence 6 Other (Specify) Describe how Injury occurred
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Manhi Sains MD D24023211139517

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

HARSHI BAINS, Sinai Hospital of Baltimore

31. Deterflied (Mapth, Dey, Year)

32. Flegistre's eignature

33. Flegistre's eignature

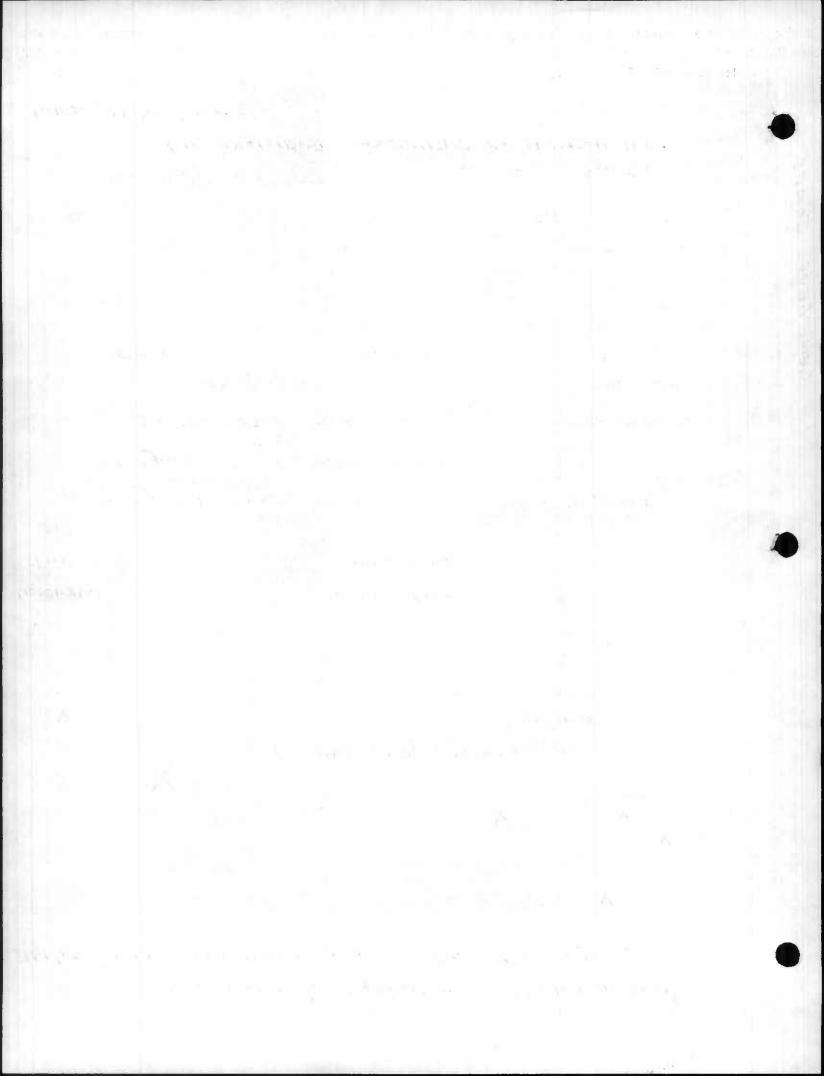
Andress

D2402321HB9517

January 27, 1998

Registrar

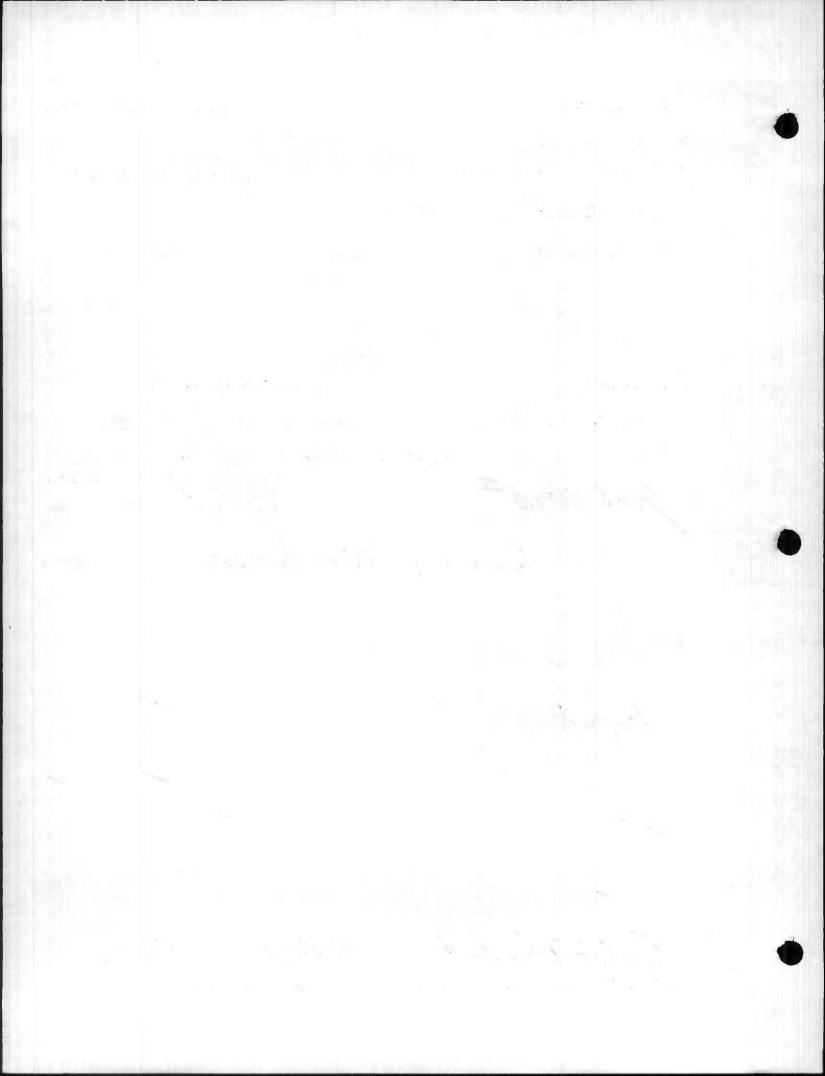
State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of N	iaryianu /	Certificate of		, ,	eg. No.	0.	2966
Physici	an	1. Decedant's Nama (First, Middla, L	ast)				2. Dete of Daar Month		Year	3. Time of Death
/Medi		Frank Peter Kolm					January		998	8:30 AM
Examir	ner	4e. Fecility Nama (If not institution, gr 5307 Springlake V		7)		4b. City, Town, or L Baltimore		4c. County N/A	of Death	
Funeral Director		057-16-2685	Sax 7. A 1 X M 2 □ F	ga (In yrs. last b 94	yrs. If Undar 1 Yaa Months Days		8. Data of Birth (Month, Day April 9	, Year) , 1903	9. Birthp Court New	laca (Stata or Foreign try) York
Maryland f ahow	tor	Usual Rasidanca of Dacedant 10a. Stata 10b. County Maryland N/A			wn or Location ltimore				1	0d. Inside City Limits
h with the	al Direct	10e. Street end Numbar 5307 Springlake V	Vay		10f. Zip Coda 21212	2	1	Og. Citizan of V		
5-0020 72 hours efter death with the Maryland natural; or items 23a or 28a-f ahow lical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ★ Navar Married 2 Married 3 □ Widowed 4 □ Divorced	12. Wes Dacedan Armed Forcas 1 ☐ Yas 2 X If Yas, Giva Yeer or Datas	? No	13. Was Dacedant of If Yas, specify Cu 1 ☐ Yes 2 🔀 No	ban, Maxican, Puarto	pecify Yas or No- Rican, atc.)		k, Whita,	
	Completed	15. Dacedant's E (Spacity onty highast gi	ducation rada complatad) College (1-4or		a. Decedent's Usual Occi (Giva kind of work don lifa. DO NOT usa ratir	a during most of work ed)	king	16b. Kind of Bu	islnass/Ind	
d 21 filed w Hygler other th	S	11			clerica			baı		
Maryland 212: d 2 should be filed within th end Mental Hyglene. 7 is merked other than traumatic event, the M	To Be	17. Father's Nama (First, Middle, Las Frank S. Kolm	1)			18. Mothar's Nam Margret	ta Lille		a)	
Mary d2 shouth end N		19e. Informant's Name/Ralationship Ferdinand P. Dier			b. Mailing Addrass (Strae					
0 0 0 - 2		20a. Method of Disposition 1	☐Ramoval from State	20b. Placa camat	307 Springla of Disposition (Nama of ary, cramatory or other pl John's Cemet	aca)		e, MD 20c. Location - Queens,		wn, Stata
Baltim permit. Pag Department Important: I any Injury o		21. Signature of Funaral Sarvica Lice	**			ress of Fecility Mit		iedefel		
Physician end Examiner as the bunal-transit	edical Examiner	Immediate Cause (Final disease, or continued, or heart failure. List only immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last		Due to (or es a	. 1	y die				Approximate Interval Batween Onsat end Death
P.O. BOX hat the death certified by the ettending detached for use a	by Physician/M	Part II. Other significant conditiona	dcontributing to death	but not resulting	In the underlying cause g	ivan In Part I.	1 🗆 Y	ea 2 No	3 ☐ Prol	o the cause of death? bably 4 ☐ Unknown
2 5 5 5	Completed	advance	d age				24a. Was a perfor	n autopsy med?	av	ere autopsy findings ailabla prior to mplation of ceusa daeth?
- F # &	Con						1□ Y	es 20No	t [Yas 200
of Vital Physician: The this certificate ral director, pag	Be	25. Wes case rafarrad to medical axaminer?	Hospital:		10	26. Plece of Deer				
Division of Vita To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicida 4 Homicide	28a. Date of Inj (Month, D	ay Year)	Time of lnjury 28c. Inj	ury at ork?	oma 5 Rasidi 28d. Dascribe hi 28f. Location (S City or Town	ow Injury occurr	red	y) N Routa Number,
To the Hospital Within 24 hours of To the Funeral Completely filled	edical Co	29a. Cartifiar 1 Certifying P	miner: On the basis	of axamination a	ge, daeth occurred et the nd/or invastigation, in my	time, data and place, opinion, death occur	end due to the c red at the time, d	eusa(s) and ma late and place,	innar as s and due to	tatad. the cause(s)
To the within To the comple	Mec	29b. Signature and titla of certifier	2 And manner	1	29c. Licar	nse number	/ 2	9d. Data signe	d (Month)	Day, Year)
X		30. Nama and address of person whe				2000	1	1/5	0/7	7
		Carl S. Friedmar 31. Data filed (Month, Day, Year)			mount Ave.	Towson,	MD 2128	36		
Sta Registr		FEB 0 3 199	8 goine	trars Signatura	Mandall					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 19a per FH G-756 2/6/98 dh Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Catherine Kina Month 7:15 p.m. January 1998 28, 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Dundalk 8186 Midhaven Road Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) Nov. 7, 1955 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign Deys Months 1 ☐ M 2 🖫 F Maryland 216-66-2777 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. Stete 10b. County 1 ☐ Yes 2 ☑ No Dundalk Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21222 8186 Mid Haven Road 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 ☐ Never Merried 2(X Merried Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Detes 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 years 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Patricia Pisani Robert W. Sampson 19a. Informant's Name/Reletionship (Type, Print) Daniel David E. King, Sr./Husband 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 8186 Mid Haven Road Baltimore, Maryland 21222 20b. Placa of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Cremetion _3 Removel from State Sacred Heart of Jesus Cem. 2/2/98 Other (Specify) Dundalk, Maryland 21 Shoutors of Fugarel Service Lick 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 a death. Do not enter the mode of dying, such as cardiec or respiretory errest, Omeno Res 23a. Enter the disease, or complications that cause on each income cause on each income cause on each income cause on each income. Immediate Cause (Final Acute Myeloid Leukemia 13 months disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in death) Lest Due to (or es e consequenca of) Due to (or es e consequence of). 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

other

8

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours effer death next of Health and Mentel Hygiene.

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

the Marylend

Examiner Physician/Medical the 80 980 Completed by

25. Wes case referred to medical

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 No

27. Manner of Deeth

Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

physical signed by t page 2 hes certificate funerel director this After 24 hours efter deeth.

Funeral Director: A

Division of Vital Records, P.O. Box 68760 or Attending Physician: Be 10 Certification:

within 2

Registrar

Hospital

To the

Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Comparison of the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner steted. Medical (Check only one) 29c. License number 29b. Signeture end title of certifier RESOOC 30. Name end eddress of person wo ompleted cause of death (Item 23e) (Type, Print)

28e. Dete of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpetient 3 DOA

28e. Placa of tnjury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

29d. Date signed (Month, Dey, Year) January 29, 1998

1 Yes 2 No

No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Piece of Deeth (Check only one)

Oncology Center, Johns Hopkins Hospital, Baltimore, MD

28c. Injury at Work?

1 ☐ Yes

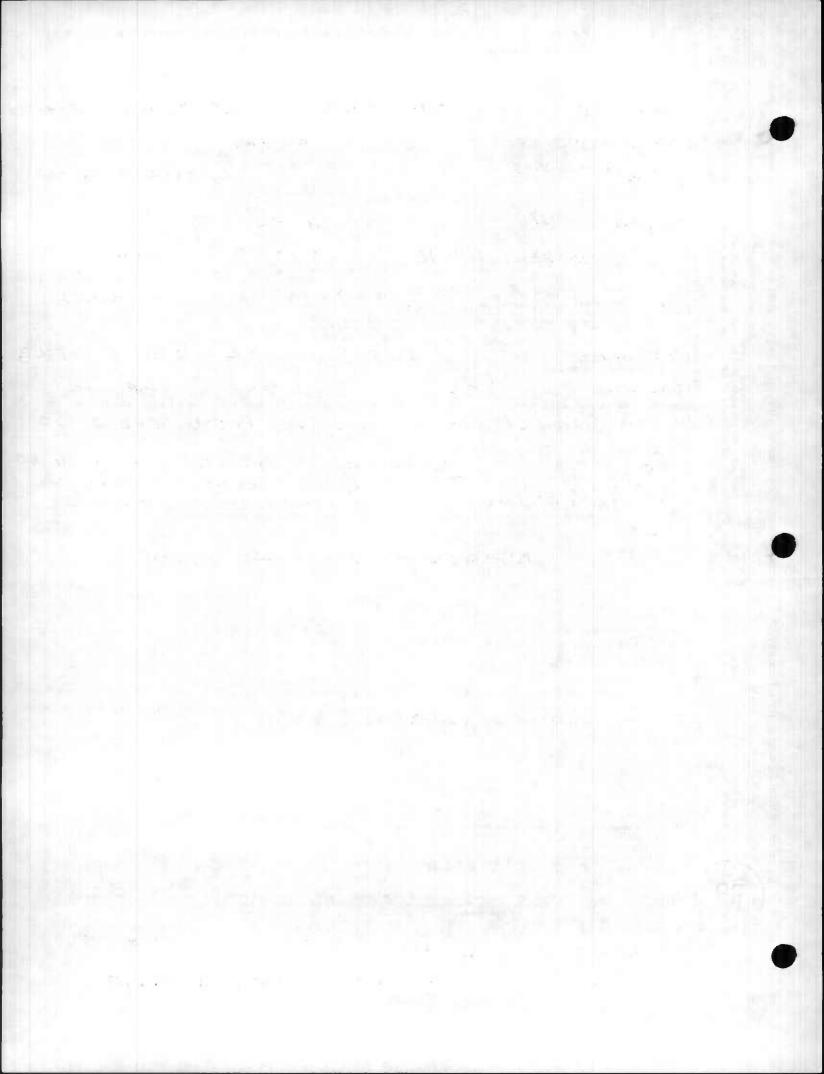
2 No

Smitha Subramanyan M.D. 31. Dete filed (Month, Day Year) 32 Registrar's Signature Januare

the state of the s Name of the state central factor in the factor in the second all " malatant when he did not and

W	ILFRED	KE	SS	State of Maryland		partment of Fertificate of			giene	029	68
	Physici /Medio Examir	al	Decedent's Neme (First, Middle, Last W1 L F RE D 4e Facility Name (If not institution, give	WASHINGTO	N	KESS	4b. City, Town, or	2. Dete of Dea Month JAN. Location of Death	Dey 30. 199	Year 8 1	O:24 AM
	Funeral Director		HARBOR HOSPITAL 5. Social Security Number 17-26-5872 Usual Residence of Decedent		ast birthday 7 Yrs.	y) If Under 1 Year Months Days	BALTIM If Under 24 Hrs Hours Min.		h Year)	9. Birthplece (Country)	State or Foreign
	with the Maryland a or 28a-f show		10a. State 10b. County MARYLAND N	10c. City,	, Town or I	BALT	IMORE		/	U	side City Limits Yes 2□No
020	urs after death with the air, or items 23e or 2:	by Funeral Director	10e. Street and Number 3 5 0 4 Book 11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	ERT DRIV. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 Mos - 15 If Yes, Give Yeer or Dates: /2 - 3/-	S. 13	. Was Decedent of No. 1 Yes 2 No.	2 /2 3 dispenic Origin? (S an, Mexicen, Puer Specify:	25		•	
N-61212	within 72 ho iena. than "naturi	Completed	15. Decedent's Edu (Specify only highest gred	cetion	(Giv	edent's Usuel Occup re kind of work done DO NOT use retire	during most of wo		16b. Kind of Bu		FFICE
rylana	nould be filed d Mental Hygi narked other natic event, I	To Be Co	17. Fether's Name (First, Middle, Last) GEORGE W	,			18. Mother's Na	me (First, Middle,	Maiden Sumam	e) 200/4	5
aitimore, mai	nit. Pages 1 and 2 sh artment of Health and ortant: If Item 27 is m injury or other traum		19a. Informent's Name/Relationship (7) ROSALIE GAITH. 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	ER (NEICE) Removel from State ABOVE	415 ece of Disp metery, cr	HARLE, position (Neme of emetory or other ple	M AVE,	PA SAD Dete	ENA M 20c. Location -	D, 21 City or Town, S	122 tate RYLAND
	Physician /Medical Examiner	ner	shock, or heart failure. List only o	ATHOROSCO	. Do not e	2140 Ni nter the mode of dyi	FULTON ng, such es cardia	AVE, B	<u>ALTIMOR</u> rest,	RE, MO,	
Box 68/60,	leath cartificate be axecuted attanding physician and I for usa as the burial-transi	in/Medical Examin	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest	0		equence of):					
s, P.O.	tha c	by Physician/Med	Pert II. Other significent conditions con CHNOMIC OBSTR	ntributing to death but not result				10		3 Probably	4 Unknown
Hecord	has b	Completed						24a. Was perfo	en eutopsy rmed?	availeble completi of death	ion of ceuse
rvitai	Physician: The	To Be C	25. Was case referred to medicet examiner? ★XYes 2□ No	Hospital: 1 ☐ Inpatient ★★ E	ER/Outpati	ent 3 DOA Ot	her:	ath (Check only o	ne)		
IVISION OF	Arending Ph In reath. In the funeral	Hillication:	27. Manner of Death XNaturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Date of Injury (Month, Dey Year) 28e. Place of Injury - At hor building, etc. (Specify,	y at k? Yes 2 □ No 28d. Describe how Injury occurred 28d. Locetion (Street end Number or Rural Route Number, City or Town, Stete)						
(RB	Sical De	29a. Certifier (Check only one) 1□ Certifying Phy. XX Medical Exami	elcian: To the best of my know ner: On the basis of examinati and manner stated.	/ledge, dea	ath occurred et the ti Investigation, in my d	me, date end plec oplnion, death occ	e, end due to the urred et the time,	cause(s) and ma dete and place,	nner es stated. end due to the d	euse(s)
	To the To the Comple	Me	29b. Signature and title of certifier	rethele	My	29c. Licen:	se number		29d. Date signed	d (Month, Dey,	Year)
	6+1		30. Name end address of person who co			nn Street	, Baltimo	ore, Mar	yland 21	.201	

State Registrar 31. Date filed (Months Day 938



10f. Zip Coda

| Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foraign Months | Days | Hours | Min. | Jan. 28, 1917 | Balto., Md.

10g. Citizan of Whet Country?

10d. Inside City Limits

1 ☐ Yas 2 ▼ No

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02969 Certificate of Death Item #3 per Phy G756 2/3/98 EW 2. Deta of Death Month . Decedant's Name (First, Middla, Last) 3. Time of Death **Physician** Margaret Elizabeth Kromm 9, 1998 Jan. Unknown /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 2428 Keyway Dunda1k **Baltimore**

Yrs.

10c. City, Town or Location

Dunda1k

7. Age (In yrs. last birthday)

Funerai Director

5. Social Sacurity Number

213-03-9549 Usual Rasidence of Dacedent

10e. Street and Number

10a. Stete

Director

6. Sex

Baltimore

10b. County

1□M 2□F

32. Ragistra

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Depertment of Health and Mental hygiene.

Timportant: If team 27 is marked other than "naturel", or items 23a or 28af show any injury or other traumatic event, I'm Medical Experiment he notified at

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

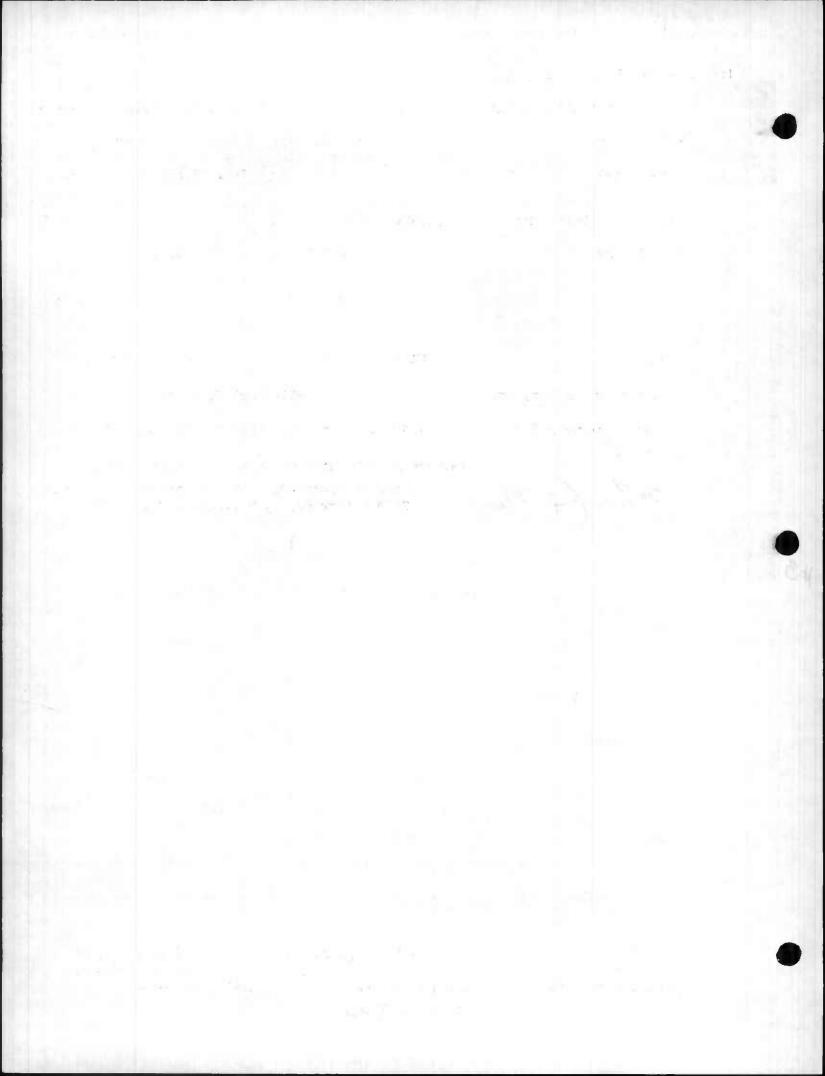
To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

2428 Keyway			21222	U.	U.S.A.			
1. Marital Status 1 Navar Married 2 Married 3X Widowed 4 Divorced	12. Wes Decedent Evar In U,S Armad Forces? 1 ☐ Yes 2 M No If Yas, Giva Year or Dates:		nt of Hispanic Origin? (S y Cuben, Maxican, Puai No Specify:	Spacify Yas or No- rto Rican, etc.)	14. Race - Amari Black, Whita, Specify:			
15. Decedant's Edu (Specify only highest grad	cation la complated) Collaga (1-4or 5+)	lifa. DO NOT usa	dona during most of wo	orking	Kind of Business/In			
12 7. Father's Nama (First, Middle, Last)		Clerk	18. Mother's Ne	me (First, Middla, Maida	partment In Sumame)	Store		
Albert W. Mille 9a. Informent's Name/Ralationship (7)		19b. Mailing Addrass (oeth W. Bet!		Coda)		
Dennis Kromm / De. Method of Disposition 1 □ Burial 2 10 Cramation 3 □ F 4 □ Donation 5 □ Othar (Spacify)	20b. Pla Ramoval from State Ba1t	imore—Washi	ngton Crema	l- 13 -98	linois 6 Location - City or To	own, Stata		
1. Signatura of Fuparal Service Ligans	2 Vien	Bradley-		rowski-Mattl				
3a. Part1. Entar the disease, or complete shock, or heart failure. List only o	ications that caused the death. na causa on each line.	Do not antar the mode	of dying, such as cardia	Rd., Balto. ac or raspiratory arrest,	,MQ . 2122	Approximata Intarval Batween Onset end Death		
nmadiata Causa (Final isaasa or condition asulting In daath)	Con	via .	mest					
	Dua to (or	as a consequance of):	ie hen	it dis	esse			
any, laeding to immadiate ausa. Entar Undarlying ausa. (Disease or Injury hat initiated avants sulling in daath) Last	Due to (or a	es e consequence of):						
nt II. Other algnificant conditione cor	ntributing to death but not result	ting in the underlying cau	sa givan in Part I.	23b. Did tobacc	o uae contributa t	the causa of death		
				1 🗆 Yas	2□ No 3□ Pro	bably 40 Unknow		
				24a. Was an aut performed?	ev	ere eutopsy findings eilable prior to mpletion of causa daath?		
the same of				1 ☐ Yes	2 1040 1	☐ Yas 2☐ No		
. Was casa rafarrad to medical axaminar?	1	11		eath (Check only ona)				
TU Tes ZIEMO		R/Outpetient 3□ DOA		Homa 5 Rasidence		y)		
Mannar of Daath 1 D Natural 5 □ Panding 2 □ Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Time of 28c Injury M	: Injury et Work? 1 ☐ Yas 2 ☐ No	28d. Dascribe how Inj	ury occurred			
3 Suicida 6 Could not be datarmined	28a. Place of Injury - At hon building, atc. (Spacify)	na, farm, street, factory,	office	28f. Location (Street & City or Town, Sta	and Number or Run ta)	il Route Number,		
Pa. Cartifiar 1 Certifying Physic (Check only one)	sician: To the best of my know nar: On the basis of axaminetic and manner stated.	ledga, daath occurrad at on and/or Invastigation, Ir	tha tima, data and place my opinion, daath occ	e, and dua to tha causa(urred at tha tima, data a	s) and manner as s nd place, and dua t	tatad. o tha cause(s)		
b. Signature and title of certifier	0	29c. l	lcensa number		ata signed (Month,	Day, Year)		
1								
Theken a	m Suco	I my	19159	E University	on 13,1	998		

State Registrar

Frederick .. 31. Date filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item #10e.19b per FH G756 2/3/98 EW Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 130 Pm KALISH ANO ARY /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Death County of Deeth **Examiner** NORTHWEST HOSPITAL CENTER RANDALLSTOWN PALTIMORO If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Dey.
DEC 22, if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Year) 1903 Deys 1□ M 2 F Yrs 215-43-5590 94 Director RUSSIA Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mariical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE OWINGS MILLS 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 16 BITTER ROOT CT. APT. #P E 21117 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter. Depertment of Health and Mentel Hyglone. Important: If item 27 is marked other than "natural", or ite, any Injury or other traumatic event, **** Mexical Examination 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ WHITE 3 ₩idowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ PHYSICIAN MEDICINE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be KRISTIAN FREK BERTA (UNKNOWN) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) VICTOR KALISH / SON 16 BITTER ROOT CT. APT. -F E OWINGS MILLS, MD 21117 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Purial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) OHEB SHALOM MEMORIAL PK 1/30/98 REISTERSTOWN, MD 22. Name end Address of Fecility 8-900 Kliestersion evinson + Bros Fail. Enter the disease, or complication. Det caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Examiner sician end burief-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of) physician s the buriel P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): 98 0 been signed by the should be deteched Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Records. by 24e. Wes en eutopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed hes 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital or within 24 hours To the Funeral 1 Critifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner steted. 29a. Certifier

29c. License number

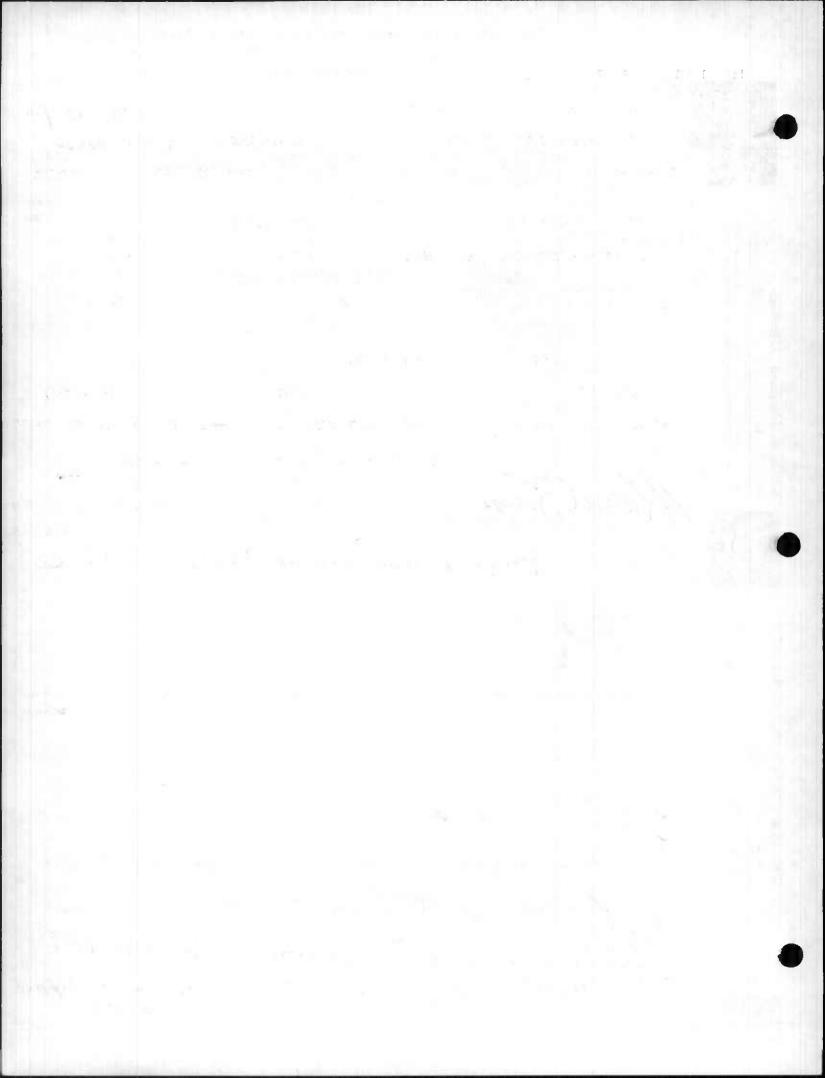
Rd

Registrar

29b. Signature and title of cartifier

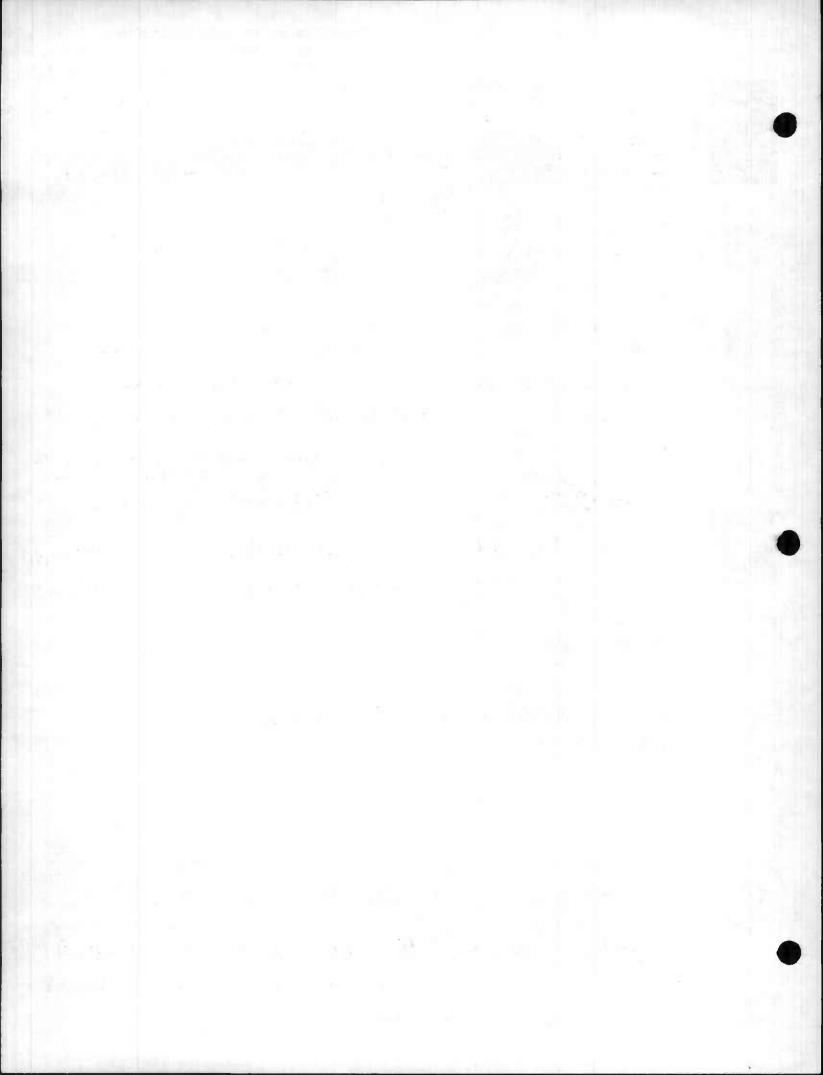
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wa Davidson



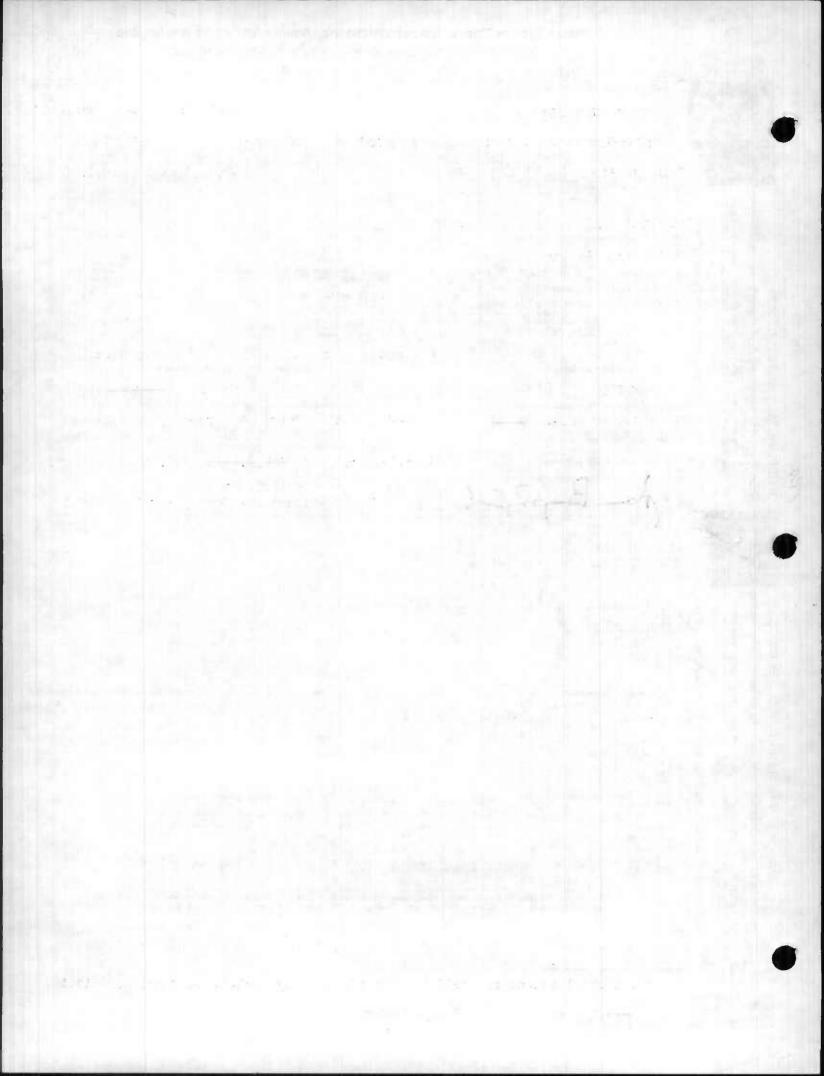
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia Medica/		Joyce K	Lenny.				Janua	M 21,	1998 7:00
Examine		4e. Fecility Neme (If not institution, give	re street and number)			4b. City, Town, or Lo	ocation of Deeth	c. County	of Deeth
		5. Sociel Security Number	Sex 7. Age	Marina land blade da	If Under 1 Year	B Wto	more		
uneral rector			1 M 2 SkF	(In yrs. last birthday	Months Days		8. Date of Birt (Month, De 09-08	, Yeer) - 40	9. Birthplace (Stete or For Country) Virginia
M III		10a. State 10b. County		10c. City, Town or I	Location				10d. Inside City Lir
THE PERSON	ctor	Maryland Car	roll	West	Minster				1 Yes 2
23a or 28	Funeral Director	10e. Street end Number 1281 S. Pleas	ant Valle	y Road	10f. Zip Code	21158		10g. Citizen of W USA	het Country?
Exp.	þ	11. Maritel Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:	ver in U,S. 13	Was Decedent of If Yes, specify Cut 1 ☐ Yes 22 No	Hispenic Orlgin? (Spoen, Mexicen, Puerto Specify:	ecify Yes or No- Ricen, etc.)	14. Race Black Specify:	American Indian, K, White, etc.
"netural".	eted	15. Decedent's E (Specify only highest gra	ducetion	16e. Dec	edent's Usuel Occu	petion during most of work ed)	ina	16b. Kind of Bus	siness/Industry
than	Completed	Elementary/Secondery (0-12)	College (1-4or 5+) life.	Homemal		"ig	The H	Home
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em 27 is marke other traumatic		19e. Informant's Name/Reletionship (Dallas B. Kenn		19b. Mei 128	ling Address (Stree	easant V	alRoute Number	Rd. We	State, Zip Code) est Minster 21158
= 2		20a. Method of Disposition 11☑ Burial 2 ☐ Cremetion 3 ☐			emetory or other ple		Dete	20c. Location - 0	City or Town, Stete
Important: any injury o	-	4 ☐ Donetion 5 ☐ Other (Specification 21. Signature of Funeral Service Linear			zer Ceme		1-26-9		nd Hill, Vi ome, Inc.
any ir		1/1/1/	4		T	O Dov	206		
		23e. Pert1. Enter the disease, or com shock, or heert failure. List only	plications that caused the	he death. Do not e	nter the mode of dy	Purcelly ing, such es cardiec	ille, or respiretory er	VA 2013 rest,	34-0896 Approximete
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edical miner		tmmediete Ceuse (Final diseese or condition resulting in death)	. Sudd	len c	ardia	c dear	th		unknow
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items:18,19a,20b per FH G-756 2/6/98 dh Reg. No. 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Day Month Yaar **Physician** FEBRUARY 2,1998 6:37 AM FRANK HENRY LANDA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, giva street and number) Examiner BALTIMORE RIVERVIEW NURSING CENTRE, INCORPORATED BALTIMORE If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Min. Months Hours 11 M 2□ F Davs Feb. 18, 1909 218 30 5128 88 Maryland Director Usual Residence of Deceden the Maryland 10d. Insida City Limits 10a State 10h Count 10c. City. Town or Location is 1 end 2 should be filed within 72 hours after death with the Marylar of Haalth and Mental Hygiena. It have 23 or 23e-1 show other traumatic event, the Medical Example at marked other the Medical Example at marked other. 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7730 Gough Street 21224 USA Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Dacedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: White Specify: by 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Owner / Operator 12 Food Store 18 Mother's Name (First Middle Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) Be Joseph Landa Hedwig (unknown) Ulrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (son) step son John S. Zavorotny 15390 Magnolia Drive New Freedom, Pa 17349 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1
Department of H
Important: If Itar
any Injury or off 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 2/5/98 Feb. 2, 1998 Parkwood Cemetery Baltimore Co. Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home PA 1407 Old Eastern Ave Essex, Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, book, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical e secretia 400 Examiner Due to (or as a consequence of): Examiner attanding physician and for use as the buriel-trensit certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of) 88 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 nknown 14 n docome Records, by 24b. Were autopsy findings evailable prior to Completed 24a. Wes an eutopsy performed? Deen Sphana completion of cause of death? certificata has b lirector, paga 2 si 1 Yes 2 TNo 1 Tyes 2 No Division of Vital 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending Investigation Hospital or Attanding 1 Natural 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 6 4 THomicide 24 hours Funeral etely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the I vithin 2 To the I complet 29c. Licanse number 29d. Data signad (Month, Day, Yaar) 29b. Signature and title of certifier wall amound 30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 5517 "A" Ritchie Highway Dr. Michael Schwartz Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State who Davidson Registrar n 3 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 540/AU Evelyn Dashiell Ebert Ludvik FEbruary 1998 01 4a. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deetly 4c. County of Death Keswick Nursing Home Baltimore If Undar 1 Year | If Under 24 Hrs. 5. Social Sacurity Numbar 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthpiece (Stete or Foreign Country) Deys 1 M & CVF Months Hours Yrs. 212-10-3400 94 Dec 7,1903 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyres 2 No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whef Country? 700 W. 40th Street Keswick Nursing Home 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? 11. Marifal Status Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - Amarican Indlen. Bleck, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: 1 Never Merriad 2 Married 1 Yes 2√No Specity: 3 ☑ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementery/Secondery (0-12) College (1-4or 5+) Schools Teacher 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William Charles Dashiell Elizabeth Jennings Merryman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) John J. White 7300 Knollwood Road Towson, MD 21286 20e. Method of Disposition 20b. Place of Disposition (Neme of cematery, cremetory or other plece) Dete 20c. Location - City or Town, Steta 1XX uriel 2 ☐ Cremetion 3 ☐ Removei from Stata Loudon Park Cemetery 2/4/98 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Burgee-Henss Funeral Home, PA 3631 Falls Road Baltimore, MD 21. Signature of Funeral Service Licen 21211 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a. List only one cause on each line. Approximata Intervel Between Onsat and Death Immediete Cause (Final Cerebro-vascular disease and history of 5 trokes diseese or condition resulting in deeth) Hypertension unlowere Sequantially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Dua to (or as a consequence of): Due to (or es e consequence of): Part II. Other significant conditions confributing to death but not rasulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy performed? 200 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminar? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medical Examiner

Physician

Examiner

10a. Stete

Director

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r than "natural", or items 23s or 28s-f shorting well the motified at

I Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked otherny injury or other traumatic event once.

12/07/03

2/21034

/Medical

Examiner physician end st the buriel-trans Physician/Medical for use es 3 signed by det by Completed pege 2 s certificate Be Certification: To this After Director: / Medical

P.O. Box 68760 Records, Division of Vital or Attending Physician: efter death. the Hospital o hin 24 hours ef the Funeral DI upletely filled in To the Within 2 To the

Registrar

27. Manner of Deeth

1 Neturel

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending Investigation

6 Could not be determined

29b. Signature and titla of certifier que ges (7) 29c. Licansa number

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner steted.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year) February 1, 1998

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D. BABELLE

30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

D. PRARETIE TACGREGOR, KESWICK, 700 W 40 The Preeb, Balfundy, Wed 21211

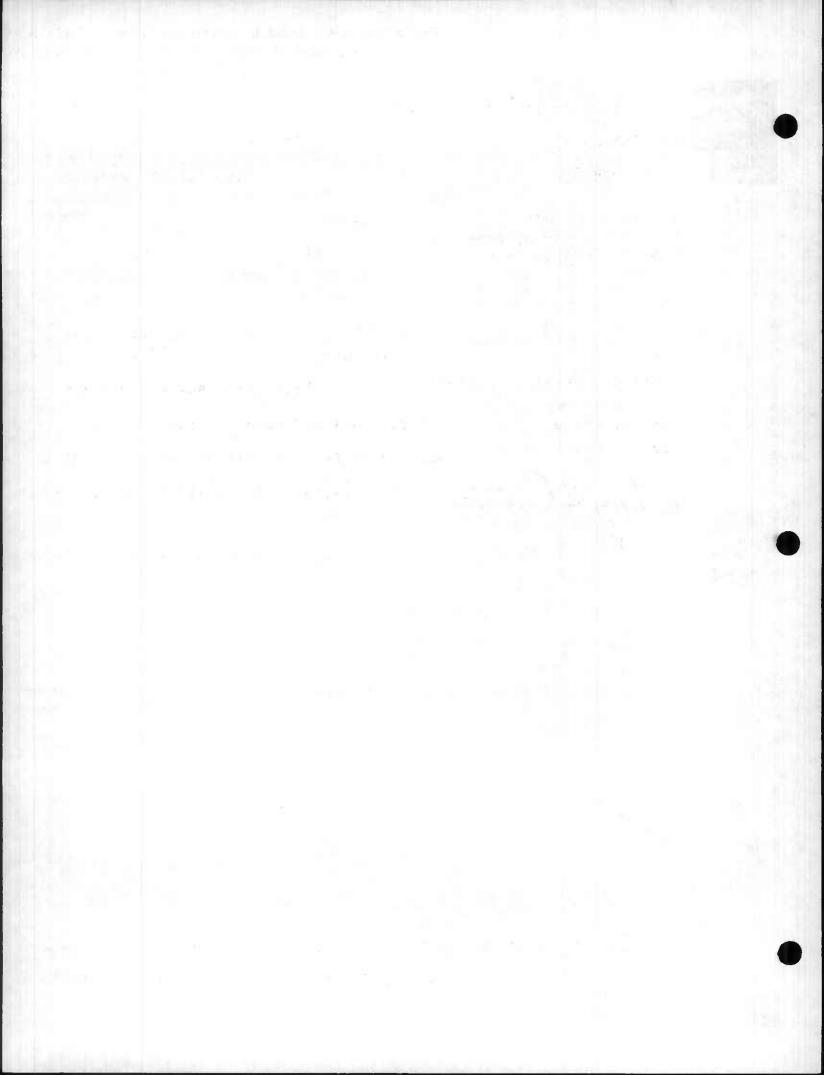
28d. Describe how injury occurred

31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature FEB 0 3 1998 Autia Davidson-Randall

28a. Dete of Injury (Month, Dey Year)

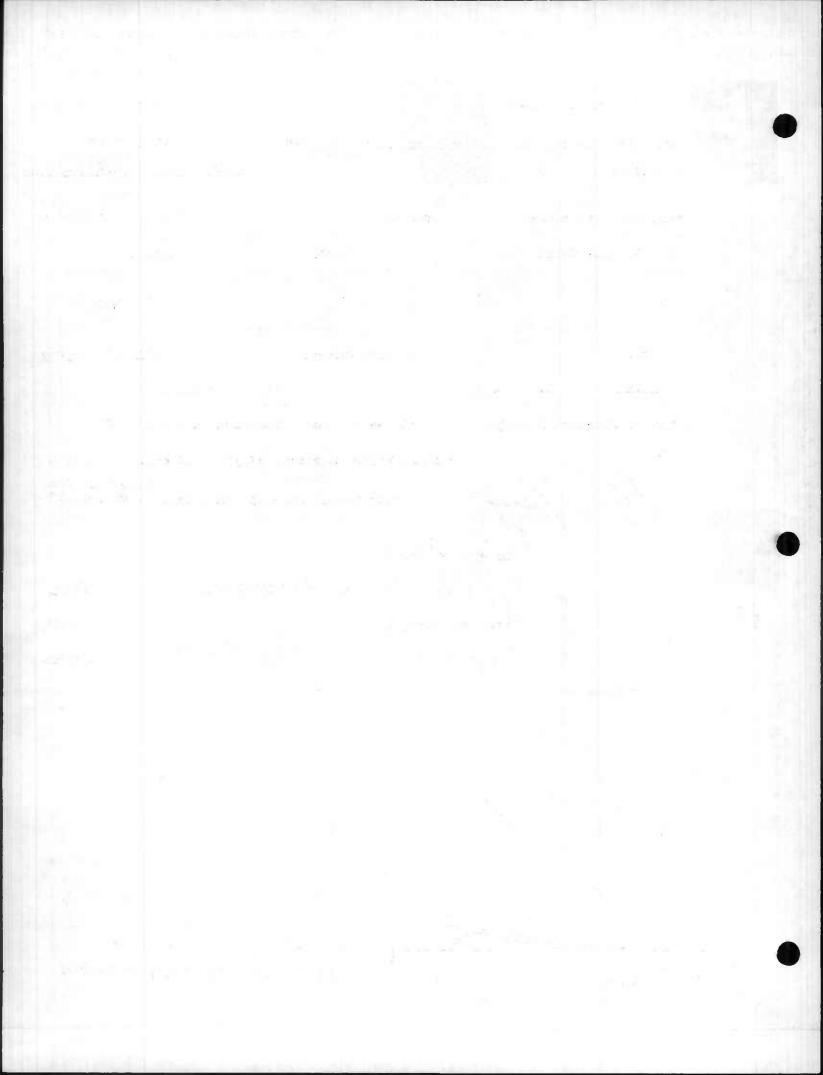
28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



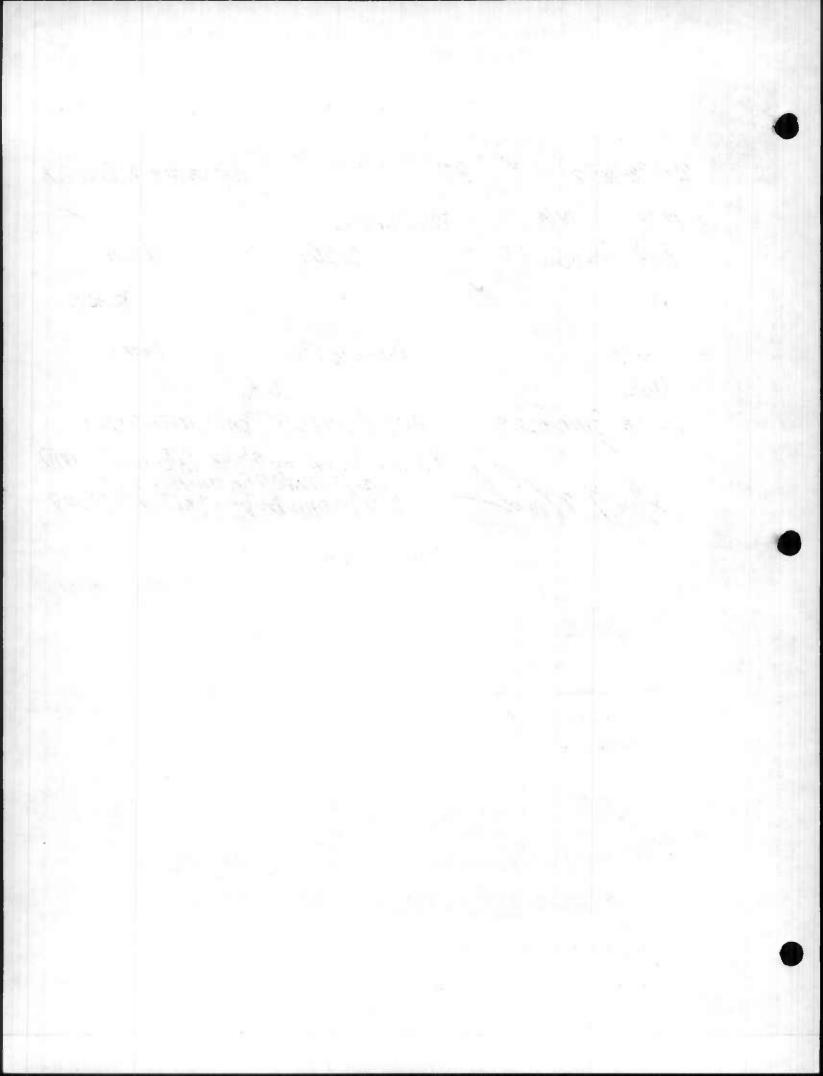
State of Maryland / Department of Health and Mental Hygiene 8 0 2 9 7 1

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/Medical Examiner	4e. Fecility Neme (If not Institu	ition, give street end nu	mber)			4b. City, Town, o	r Location of Dee			
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uneral	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 H				ece (Stete or Foreig
rector	108-01-0542	1 x M 2 □ F	86	Yrs.	Months Days	Hours Mi	March	rth ey, <i>Year)</i> 8,1911	Count Wash	ington, D
	Usuel Residence of Decedent									
28a-f show notified at	10e. Stete 10b. Cou		10c. City	y, Town or Lo	cation				10	Od. Inside City Limits
cto cto	Maryland Ba	ltimore		Towson	n .					1 ☐ Yes 2 ☐ No
or 2	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Count	ry?
234	12 Ruxview	Court			2120	04		U.S.F	<i>A</i> .	
sir, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U,	S. 13. \	Wes Decedent of It	Hispenic Origin?	(Specify Yes or N	0- 14. Rad	a - America	
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To To			owry			Ell		te1er		
Tach Tach	19e. Informent's Neme/Relation	onship (Type, Print)		19b. Mailir	ig Address (Street	end Number or	Rure/ Route Numi	per, City or Town,	Stete, Zip	Code)
n 27	Joyce L. Kavan	agh / Daugh			Galway I	Road Ti	monium,	Maryland	2109	93
r of the	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetic	2 Removel from		lece of Dispo emetery, crer	sition (Neme of netory or other ple	ce)	Dete	20c. Location -	City or To	vn, Stete
ury o	4 Donation 5 Other			laney V	/alley Ce	emetery	2/2/98	Timoniu	ım, Ma	ryland
Important: If it any injury or c once.	21. Signature of Funeful Servi	Ge Licenson		22	. Name end Addre	ess of Fecility		10	150 V	rk Road
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miner	disease or condition resulting in death)	e								
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To the Funeral Director: After this certificate has been signed by the atte complisely filled in by the funeral director, page 2 should be deteched for Medical Certification: To Be Completed by Physicia	Pert It. Other significant cond 25. Wes case referred to med examiner? 1 Yes 2 No 27. Menner of Deeth 1 Naturel 2 Accident 3 Suicide 6 Coudet Homicide 29a. Certifier (Check only one) 29b. Signature and till of cert	ical Hospitel: 1 Sa. Determined 28a. Determined 28a. Piece buildi tying Phyelcian: To the ball Examiner: On the ball end meni	npatient 2 ☐ of Injury h, Dey Yeer) of Injury - At hong, etc. (Specify best of my knowsis of examinet	ER/Outpetien 28b. Time of Injury me, ferm, str	t 3 DOA Ott 28c. Inju Wo M 1 eet, fectory, offica	26. Plece of D her: 4 Nursing ry et rk? I Yes 2 No	23b. Did 1	tobacco use co Yes 2 No s en eutopsy ormed? Yes 2 No one) idence 6 Oth how Injury occur (Street end Numb wm, Stete) ceuse(s) end m dete end place,	24b. We eve con of d 1	the cause of death ably 4 Unknow re eutopsy findings liable prior to apletion of cause eeth? Yes 2 No Route Number, eted. the cause(s)



State of Maryland / Department of Health and Mental Hygiene 8 0 2 9 7 5

			Certificate of L	Death	Reg. No.	01.510
Physician	Decedent's Name (First, Middle, Last)	BRADY	LOWER		ate of Death	3. Time of Death 1998 5.45 PM
/Medical Examiner	4a. Facility Neme (If not institution, give stre	et end number)		b. City, Town, or Location BALTIME	n of Deeth 4c. County	, , ,
Funeral Director	5. Social Security Number 6. Sex 1 M Usual Residence of Decedent	7. Age (In yrs. last	t birthdey) Yrs. If Under 1 Year Months Deys	Hours Min. 8. D	ate of Birth Month, Day, Year) 71, 23, 1910	9. Birthplece (State or Foreign Country)
death with the Maryland ms 23a or 28a-f show mstat be nulfilled at	10a. State 10b. County	10c. City, 7	9/11/10/35			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ath with to		5ti	10f. Zip Code 212	01	10g. Citizen of V	S, A
ozo urs after al', or ite	3 D Widowed 4 □ Divorced	Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 PNo If Yes, Give Yeer or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 1 No	spanic Origin? (Specify n, Mexican, Puerto Ricar Specify:	fes or No- n, etc.) 14. Rac Blac Specify	e - American Indien, ck, White, etc.
TT 6 14 12	15. Decedent's Educati (Specify only highest grede co		6a. Decedent's Usual Occupa (Give kind of work done of life, DO NOT use retired	furing most of working	16b. Kind of Bu	usiness/industry
land 212 lid be filed with entel Hygiene. ked other then ic event, the	17. Father's Name (First, Middle, Last)		HOUSEW	18. Mother's Neme (Firs	at, Middle, Meiden Surner	ME_
Mary	19a, Informant's Name/Relationship (Type,	Print)	19b Mailing Address (Street of	and Number or Rural Roll	nte Number, City or Town,	Stete, Zip Code)
Baltimore, Incomit. Pages 1 and Department of Health Important: If Item 27 and Infortant of the Control of Item 27 and Infortant of Item 27 and Item 2	20a. Method of Disposition 1 □ Burial 2 D Cremation 3 □ Rem 4 □ Donation		e of Disposition (Name of etery, cremetory or other place) 22. Name and Address	Mary 2/3	198 Catava	City or Town, State
Baltii permit. P Depertm Importar any injus any injus	23a. Parix Enter the usease, or complications of the state of the stat	ons that caused the deeth.	270 FRET	MARCH TU Off I TON PA of such as cardiac or res	DERALLAND CHARLES BALT, N Diratory errest.	2 1/11 17,21229 Approximate
Physician /Medical	Immediate Cause (Final					Interval Between Onset and Death
Examiner	disease or condition resulting in death) a		NEUMONIA s a consequence of):			2 211472
mented fruite	Sequentially list conditions,		ASPIRATION s a consequence of):	V		5 DAYS
0 a 1 1 1 1 1		Due to (or es	s e consequence of):			
Y 1 0 0 2						
O # # 6	Part II. Other significant conditions contrib		ng In the underlying cause give	en in Part I.	23b. Did tobacco use con	ntribute to the cause of death?
w requires that the been signed by the should be deteched by Physical Physi	SEVERE	CACHEXIA			24a. Was en autopsy	24b. Were autopsy findings eveileble prior to
The law repage 2 sho	MINEMIA					completion of cause of death?
Vital Publication: The certificate irector, pag	25. Was case referred to medical			26. Piece of Deeth (Ch	1 ☐ Yes 2 No eck only one)	1 ☐ Yes 2 ☐ No
- 5 SD	examiner? 1 Yes 20 No Hose 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 Eximpatient 2LIEH	VOutpatient 3 DOA Other Sb. Time of Injury M 1 1 1	4 U Nursing Home	5 ☐ Residence 6 ☐ Oth Describe how injury occur	
Division of standing P is after death. The Director: After to ed in by the funeration: Certification:	2 Could not be	8e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. L	ocation (Street end Numb City or Town, Stete)	per or Rurel Route Number,
Division o To the Hospital or Attanding Ph within 24 hours after death To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Phyaicle 2 Medical Examiner:	n: To the best of my knowle On the basis of examination and manner stated.	dge, death occurred at the tim a and/or Investigation, in my op	ne, date end place, and d pinion, deeth occurred et	ue to the cause(s) and me the time, dete end plece,	enner es steted. and due to the cause(s)
To the within To the Comp	290. Signature and the of certifier Wasantke	kumas.	29c. License D 4 2			d (Month, Dey, Year)
8	30. Name and address of person who comp	MAR MD	821 N.EU	TAWST. S	SUITE 407	MD 21201
State Registrar	31. Date filed (Month, Day, Yeer) FFB 0 3 1998	32. Registrar's Signature	n-Randell			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month FEBRUARY 1, 1998 7:15AM NATHAN 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth GENESIS ELDER CARE CATONSVILLE MANOR BALTIMORE CATONSVILLE if Under 1 Year if Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1**∑**M 2□ F Months Deys Hours 96 Yrs. July 24,1901 213 24 0153 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 X No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 100 Governors Ct. Apt. B 21061 United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Orlgln? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No if Yes, Give Year or Detes: 1 Yes 2 X No Specify: White Specify: 3 ₩ Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Mechanic Mass Transit Admstrtn. 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas B. Lathe E11a Havdell 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Lelia L. Sowers / Daughter 100 Governors Ct. Apt. B; Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Buriei 2 X Cremetion 3 ☐ Removel from State 2/3/98 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. Dotturam 8717 Green Pastures Dr., Baltimore, MD 21286 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in death) Accident ereboo reserven < 12 hr Atheroschewsis many years Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequenca of) Due to (or es e consequenca of): Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24e. Was en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Menua Previous Cerebrouseulan 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturel
2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide

/Medicai Examiner The law requires that the death cartificate be executed attanding physicial and Box 68760 signed by the a Division of Vital Records. P.O. has this certificate Attanding Physician: director, After death. i or Attandi after death Director: A d in by the f To the Hospital of within 24 hours at To the Funeral D completely filled in

Certification:

Physician

/Medical

Examiner

Funeral Director

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Completed

Be

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Examiner

Physician/Medical

Completed by

Be

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Funeral

Director

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items 23a

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marked

mportant: If item 27 my injury or other to

Physician

AL AM

altimore,

Pages T event, the Medical Examiner must be notified

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, and due to the cause(s) end menner steted. (Check only one) 29b. Signeture end title of certifier Kaya MD

29c. License number

29d. Dete signed (Month, Day, Year) Feb 1, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 4367 GEETHA HOllms

Ferny

Psaltinone MD-21227

31. Dete filed (Month, Day, Year) State Registrar

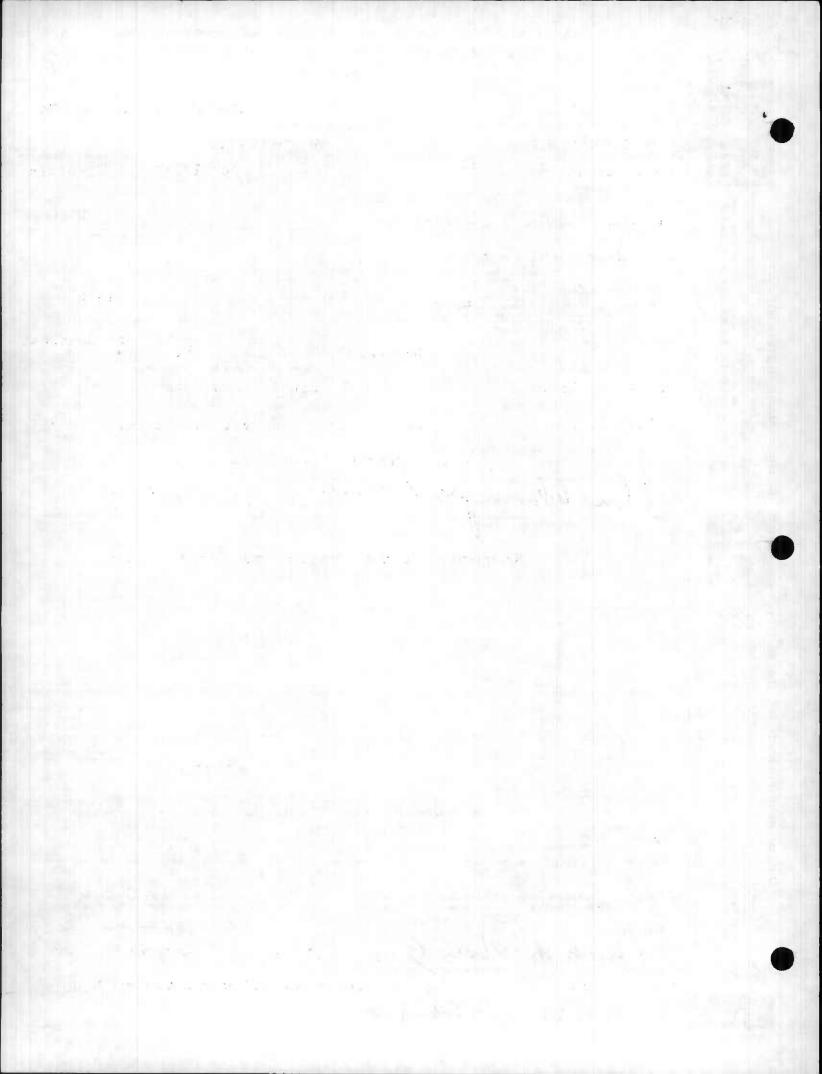
29a. Certifier

32. Registrer's Signeture relia Davidson-Randale

Part of the Control o มหาครั้งสามารถส สามารถสา พ.ศ. 2012 ค.ศ 2012 ค.ศ. 2012 ค. The second second

State of Maryland / Department of Health and Mental Hygiene

NRY	LEWIS				arylan				Death		Reg. No.	0 8	2977
п	≁ Physiciar	_	1. Decedent's Name (First, Middle, La	at)						2. Dete of De Month	Dey	Yeer	3. Time of Death
Q	/Medica	1 -	HENRY LEWIS						4 Ch To	JANUAF		998	2326PM
	Examine	r	la Facility Neme (If not institution, giv						4b. City, Town, or L		h 4c. Count	y of Death	
	Funeral Director		SINAI HOSPITAL E 5. Sociel Security Number 6. S 223-28-2290	9x 7. Ag	ge (In yrs.	last birthday) Yrs.	If Unde	r 1 Year	BALTIMORE if Under 24 Hrs. Hours Min.	In Date of Di-	1h (1922)	9. Birthp Cour	eleca (State or Foreign
		-	Usuel Residence of Decedent 10e. Stete 10b. County		10c. Cit	y, Town or Lo	cation			-			0d. Inside City Limits
	Many February	5	Maryland N/A		Ra 1	timor							XXYes 2□No
	1 the	3	10e. Street and Number	Tarie de	Dai	CIMOL	1	p Code			10g. Citizen of	What Cour	ntry?
	3a o	2	2849 West Gar:	rison Av	enue		2.	1215			U.S.A		
0	within 72 hours after death with the Manyland ena. than "naturel", or items 23s or 28s-f show be Madical Examine, must be notified at him Engage.		11. Meritel Stetus 1 □ Never Merried 2 □ XMarrled	12. Was Decedent Armed Forces? 1 M Yes 2	Ever in U No	,S. 13.		edent of h	dispenic Origin? (Spen, Mexican, Puerto	pecify Yes or No Rican, etc.)	b- 14. Re Bie	ce - Americ ck, White, by: B1a	etc.
-005	naturel',	200	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	WWII						16b. Kind of E		
21215-0020	filed within 72 ho Hygiena. ther than "nature int, the Medical	Diliplet	(Specify only highest gra	de completed) College (1-4or	5+)	(Give		ork done use retire	oation during most of worl d)	king		ore	Concrete
	電工製品 6		17. Fether's Neme (First, Middle, Last)						18. Mother's Nerr	ne (First, Middle	, Maiden Sume	me)	
Maryland	s 1 end 2 should be of Health and Mental from 27 is marked of other treumatic even		Calvin E. Lews	S					Ophelia	Ann H	layes		
lan			19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Nut							ral Route Numb	er, City or Town	, Stete, Zip	Code)
			Millie A. Lewis 2849 W. Garrison								ltimor	e, i	ID 21215
	Pages nant of ant: If it ury or o		20a. Method of Disposition 1		Md.	Plece of Dispo cemetery, cred Vete			emetery	Date 2/4/98	20c. Location Garri		
Balt	pemit. Pa Departman Important: any injury once.		21. Signature of Funerel Service Licer	James	ano	_/ M		nall	ss of Facility W Jone Londson	s,Jr F	uneral	Hom	e P.A.
		-	23a. Pert1. Enter the diseese, or com shock, or heert failure. List only	plications that countries one course on each	the deat			de of dyi	ng, such es cardiac	or respiratory	errest,		Approximate Intervel Between
Δī	Physician /Medical Examiner	0	Immediate Ceuse (Finel disease or condition resulting in death)	. Hyperte		e Arte			otic Card	liovascu	ılar Dis	ease	Onset end Deeth
68760,	physiciarrand sthe buriatiransit		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	b		r as a consec					K		
9 X	Name and	<i>u</i>		d								i	
Box	death certification of the usa as	5								l ant Bid	A-A		
P.O.	by the	l y S	Part II. Other significant conditions o	ontributing to death t	out not res	ulting in the u	naeriying	cause gr	ven in Per I.		Yes 2 No		o the cause of death? bably 4 ☐ Unknown
Ś	the digner	2	y, Hames					T.		24e. Wes	s en eutopsy ormed?	91	ere eutopsy findings
Record	has b	DIG III	7311111111							INSPE	CTION Yes 2 No	of	mpletion of cause deeth?
	certificate rector, pa	D	25. Wes case referred to medical						26. Plece of Dee	th (Check only	one)		
of V	2 00		exeminer? 1 ☑ Yes 2 ☐ No	Hospitel: 1 ☐ Inpati	ent 2 🗵	ER/Outpatie	nt 3 🗆 🖸	Otl Otl	her: 4 Nursing H	ome 5 Res	idence 8 🗆 Ot	her (Speci	(y)
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Division	T		3 Suicide 6 Could not b determined	28e. Plece of In building, e	jury - At h tc. (Specif	ome, farm, st	reet, fecto	ry, office			(Street and Num own, Stete)	ber or Run	al Route Number,
	Hospi 24 hou Funer (tely fill	בחוכם		ysician: To the best niner: On the besis of end menner si	of examina								
	To the comple	_	29b. Signature and title of certifier	. 1		1	2	9c. Licen	se number		29d. Date sign	ed (Month,	Dey, Year)
	7 . /	_	Atyph.	AVL	ac	19,1	10	0	.C.M.E.		FEBRUA	RY 01	, 1998
I	541		30. Neme end eddress of person who Stephen Radentz,		deeth (Iter			nn S	treet, Ba	ltimore	, Maryl	and 2	1201
	State Registrar	•	FEB 0 3 199	8 32. Flogist	rer's Signe	sov-Ran	dell						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 30,1998 Month **Physician** Jan. Lauer 11:30pm Anna L. /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Bowleys Baltimore Mersey Court Quarters If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Dec. 3, 1 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** MAryland Months Deys Hours 10 M 2/ F Yrs. 216-18-7939 Director 75 Usuel Residence of Decedent 10a. Stete 10b County 10c. City, Town or Location 10d. tnside City Limits "natural", or items 23a or 28a-f show Baltimore Bowleys Quarters Md. 1 ☐ Yes Ž☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21220 USA 2 Mersey Court permit. Peges 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 271s marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner manageness. Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Goldenbergs Inc. Sales 8th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Jennie Lohman Antonio Romeo 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Mersey Court Baltimore MD. 21220 Regina Lloyd /daughter 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State
4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory Inc. 2/2/98 Baltimore Md. 21. Signeture of Funerei Service Licensee 22. Neme end Address of Fecility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 the mode of dying, such as cerdiac or respiratory errest. 23e. Pert1. Enter the disease, or comshock, or heert feilure. List only Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner pulmonary disease Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or trijury that initiated events resulting in deeth) Last pug P.O. Box 68760, Physician/Medical Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detect 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Division of Vital Records. à 24b. Were eutopsy findings eveileble prior to Completed 24a. Wes en eutopsy performed? completion of ceuse of deeth? page 2 1 ☐ Yes 2 ☐ No certificate Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certifice director. 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 Homicide To the Hospital of within 24 hours of To the Funeral Discompletely filled in the Funeral Discompletely filled **Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifie 29c. License number

State Registrar

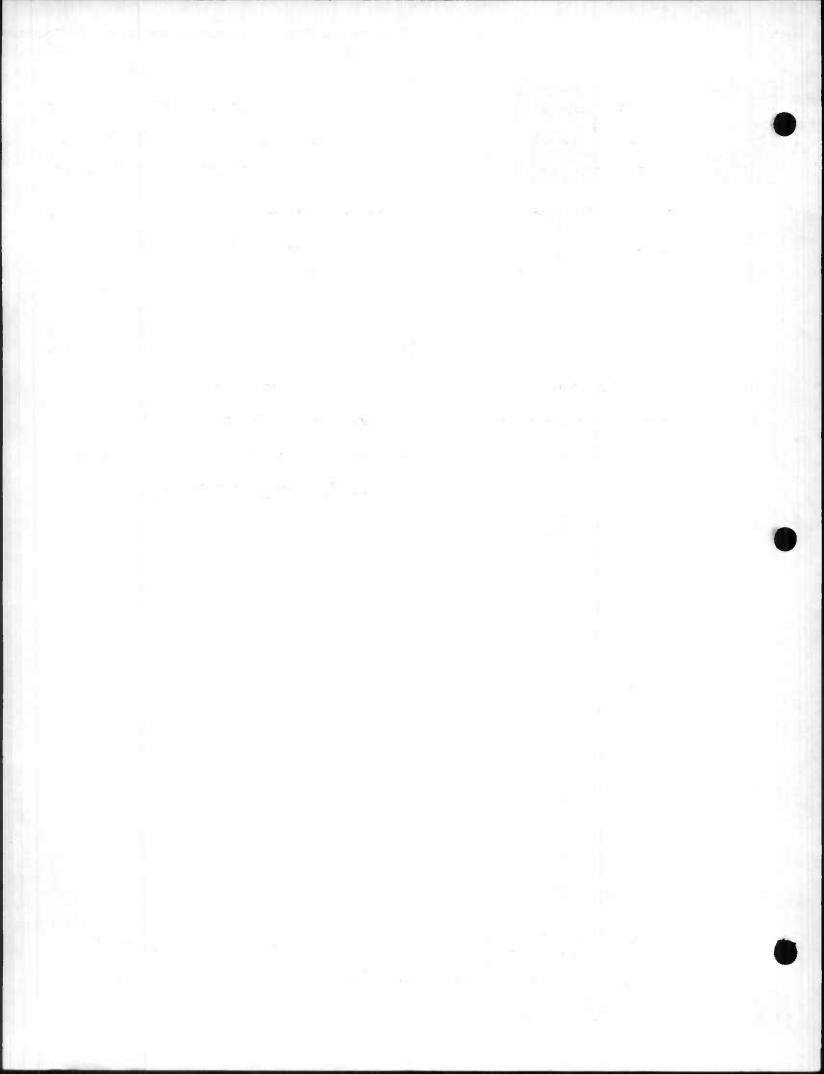
31. Dete filed (Month, Dey, Year)

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aytor 32 Registrar's Signeture ia Davidson

Hremue

30. Name end eddress of person who completed cause of deeth (ttem 23a) (Type, Print)

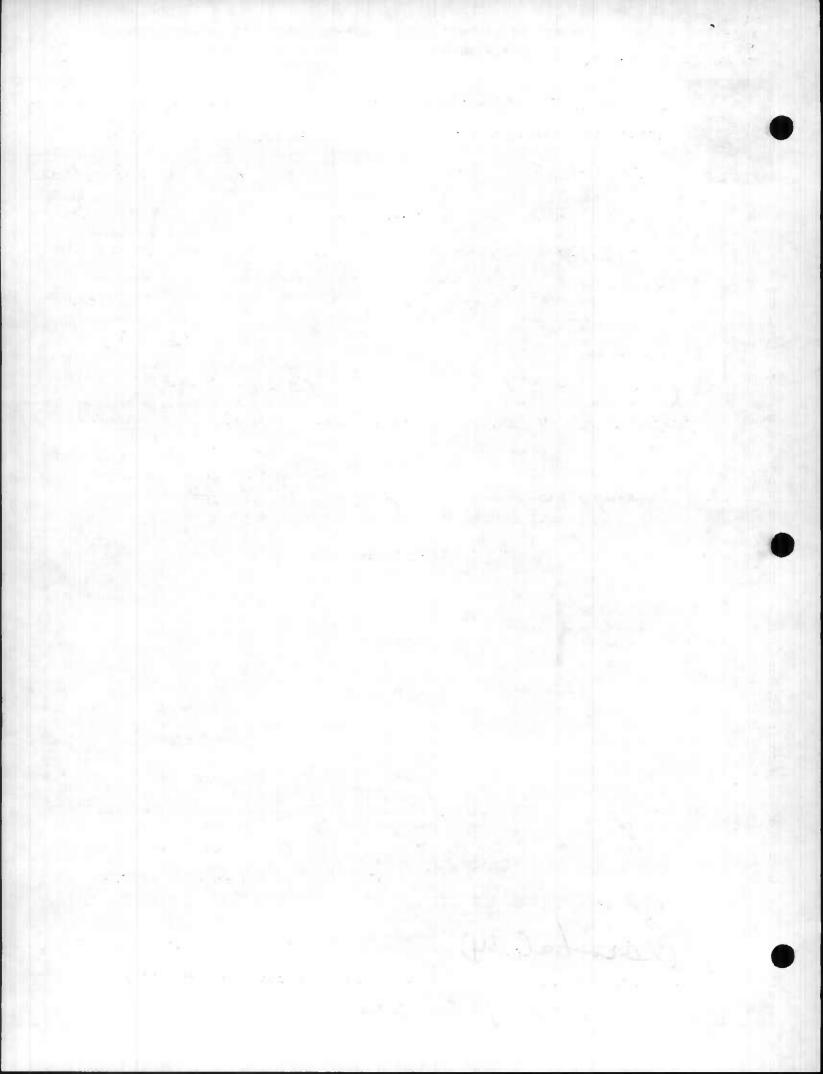


UN	IKNOWN 98	-026 JOHN MOODY	State of Marylan		artment of I rtificate of			giene B	0297	9
	Physician	1. Decedent's Neme (First, Middle, Las	n	-5			2. Dete of De Month	eth Day	Year 3.1	Time of Deeth
	Physician /Medical	JOHN LEG	MOODY	, 0,			JAN.	25, 199	8 8	3:21 PM
	Examiner	4a Facility Name (If not institution, give				4b. City, Town, or BALTIM		4c. County	of Death	
	Funeral	5. Sociel Security Number 6. Sociel Security Number 1	no	lest birthday) Yrs.	If Under 1 Year Months Days			th y, Year)	9. Birthplace (Country)	Stete or Foreign
	Director	2/3 - 82 -3003 Usuel Residence of Decedent	20 F 33	115.			Apr. 2	2,1964	Mary	mo
	Marylence show	10e. State 10b. County Marylano	10c. City	y, Town or Lo	cation / MUR				1	side City Limits Yes 2 □ No
	or 28 or 28	10a State and Number	21		10f. Zip Code			10g. Citizen of V		
	ath w	511 N. Clinton	w Street		210				513	
020	e filed within 72 hours effer death with the Maryland al Hygiene. other than "natural", or items 23a or 28a-f ahow vent, The Mascless End riches must be notified as Se Completed by Funeral Director	11. Meritel Stetus Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? U, ho 1 MYes 2 □ No U ho If Yes, Give Year or Dates: ✓ 2	S. 13.1	Was Decedent of fixes, specify Cub 1 ☐ Yes 2 X No	Hispanic Origin? (5 pan, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		e - American Indo ck, White, etc.	
Ö	2 hou	15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occu	pation	dina		usiness/Industry	
21215-0020	be filed within 72 ho tel Hygiene. d other than "nature event, the Medical Be Completed	(Specify only highest green Elementery/Secondery (0-12) 12 4 EAVS	College (1-4or 5+)	life. I	ONOT use retire	i during most of wo	, king	PRIVO	te 3USINE	SU
Maryland	Se se se	17. Father's Name (First, Middle, Last)	5+14				me (First, Middle,		10)	
any	s marke s marke sumatic	19e. Informent's Name/Reletionship (7	ype, Prfnt)	19b. Meilir	ng Address (Stree	t end Number or R			Stete, Zip Code)
	end 2 ealth a n 27 is	BAYBAYA CUTACELL	/ MOTHER	51110	.Clinto.	n Street	1		11012	
Baltimore,	permit. Peges 1 end 2 should bepartment of Health and Men important: if tem 27 is marker eny Injury or other traumatic. ance.	20a. Method of Disposition 10 Burial 2 Cremation 3	Removel from State	emetery, crer	sition (Name of metory or other pla	ace)	- 2-9P	Balt	City or Town, S	
altin	nit. Partme ortani Injury	4 □ Donation 5 □ Other (Specify 21. Signature of Funerel Service Learns	1751	- 74 0,	Name end Addr	ess of Fecility C	LIA THA	2- Klan	is F. H	7
ñ	permit. Departimonts Imports eny inju	Servy Har	io	5.	240 26	1 STERS tu	NN RUA	0		
		23a. Part1. Enter the disease, or composhock, or heart feilure. List only of	olicetions that caused the death	n. Do not ent	er the mode of dy			rrest,	Appr	oximete val Between
	Physician /Medical	Immediate Cause (Final							Onse	et and Death
	Examiner	disease or condition resulting in death)	e. MULTIPLE GUI	NSHOT or as a consec						
	je d		200 10 10	1 as a consec	querios ory.					
,	hysician end the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury that initiated events	Due to (o	r as a consec	uence of):					
8760,	physician the bun dical I	cause. (Disease or Injury that initiated events resulting in death) Last	cDue to (or	r as e conseq	uence of):					
99 xo	S S	Tosuming in death) Last	d						1	
Bo	म के क	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause a	iven In Part I	23b Did	tobacco use co	ntribute to the	cause of death?
0	d by the letech	Tatti. Otto aginican conditions co	intilibuting to death but not test	alling in the d	indenying cause g	You are all t.		Yes 2XXNo		4 Unknown
Records,	w requir							an autopsy med?	available	ion of cause
	hysician: The la nis certificete he: Il director, page 2 To Be Comp						欢	Yes 2□ No	XX Yes	2□ No
Division of Vital	clan: ertifice ector, Be (25. Wes case referred to medical	11				eth (Check only			
0	Physician: this certific ral director, To Be	XXYes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient XX	ER/Outpatier 28b. Time of	I 3 DOA		Home 5 Reside	dence 6 □Oth		
0	tal or Attanding P rs after death. el Director: After t ed in by the funers Certification:	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) 01-25-1998	Injury UNK.	Wo	ork?]Yes 2.⊟No		CT SHOT	100	
Visi	Attending or death. • ctor: After by the fune iffication	3 Sulcide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, str	eet, factory, office			Streef end Numb	per or Rural Rou	fe Number,
ā	rs after of Direction of Direct	AATOMICIO	building, etc. (Specify	STR	EET		4000	ILTON AV	ENUE	
	To the Hospital or Attanding Ph within 24 hours stafed death. To the Funerel Director: After th completely filled in by the funeral Medical Certification: 7		valcian: To the best of my know iner: On the basis of examinat and manner stated.							ause(s)
	To the within To the comp	29b. Storature and title of certified	lun			se number		JAN. 2	d (Month, Dey, 1998)	
	2		completed cause of death (Item			D=74.5		1	001	
		J. Laron Locke M.	.D. 11.	Penn	street,	Baltimo	re, Mary.	Land 212	OT	

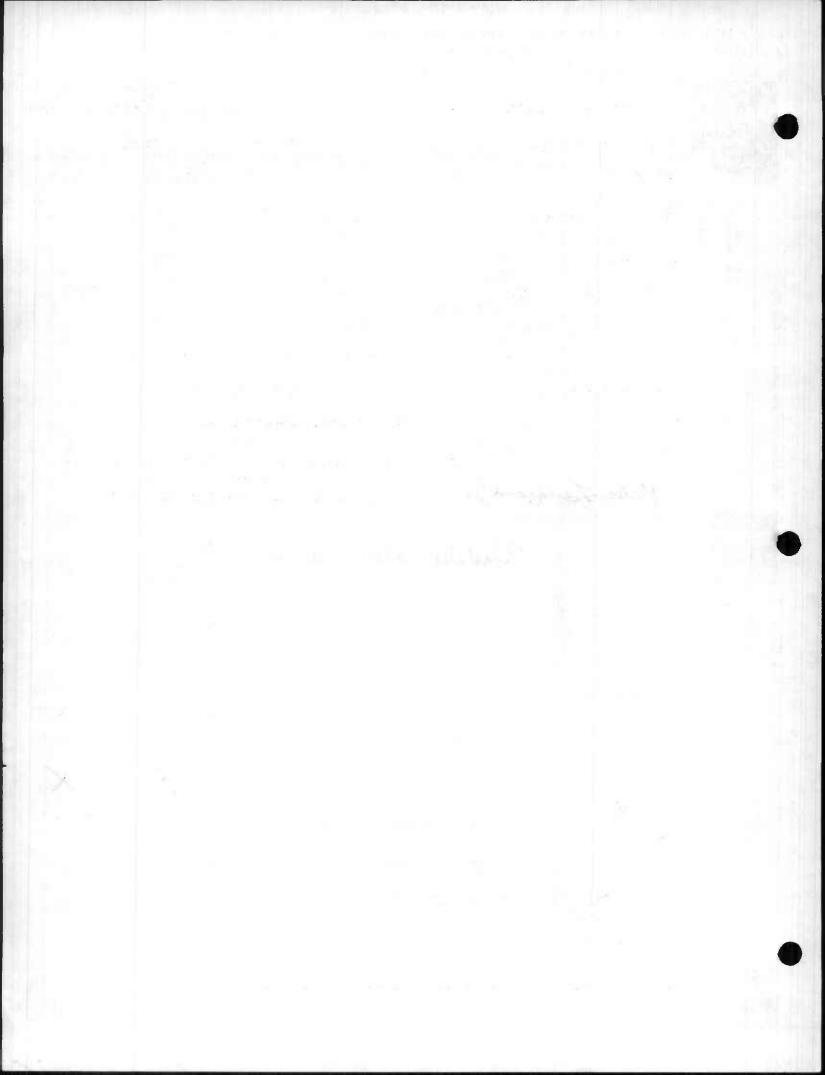
State Registrar

31. Date filed (Month, Dey, Yeer) FEB 0 3 1998

32. Registrar's Sanature



hysician		1. Decedent's Neme (First, Middle, I	Last)			e of Death	2. Dete of De	Reg. No.	3. Time of Dec
	1	A	MONTE-GR	TEFO			JANUA,	Dey Y	(ear 0 10 10/1
/Medical xaminer		4e. Fecility Neme (If not institution, g				4b. City, Town,	or Location of Deel		Deeth
Adminier		Stella Maris Ho				Tow		Baltim	
neral	Ę		Sex 7. Ag	ge (In yrs. last birthe	day) If Under	1 Year If Under 24	Hrs. 8. Dete of Bi	rth g). Birthplece (State or Fo
ector		212-10-3770	XXM 2□F	89 Yr	rs. Months	Deys Hours N	Feb. 20	1908 Ba	ltimore, MI
	-	Usual Residence of Decedent		L. 0. 7					
288-f show		10a. Stete 10b. County		10c. City, Town o					10d. Inside City LI
ke notified	3	MD Balti	more	Luth	erville				1 ☐ Yes 🏌
Or S	5 1	10e. Street and Number			10f. Zip	Code		10g. Citizen of Wh	et Country?
23 a		3 Wendslow Road				1093		USA	
at, or tems 23a or 28a-1 sho Exacting must be notified at by Funeral Director	2	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? I TYPY es 2 1 If Yes, Give Year or Detes:	No Zilily	13. Was Decedif Yes, spec	dent of Hispenic Origin cify Cuban, Mexican, Po 2 No Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Rece - Black, Specify:	American Indien, White, etc. White
marked other than "natural; imatic event, the Medical Ext	2	15. Decedent's	Education	16e. D	ecedent's Usua	ai Occupetion	sun dela a	16b. Kind of Busin	ness/Industry
Med o	2	(Specify only highest g Elementery/Secondary (0-12)	College (1-4or 5	5+) (C)	ife. DO NOT ut	rk done during most of se retired)	working		
4 0	5	8	N/A		positer	/Printer		Printing	
event Be (17. Fether's Neme (First, Middle, Las	st)				Name (First, Middle	, Maiden Sumeme)	
To T	5	Lewis Monte-Grif	fo			Lyd	ia Sander	s	
other traumatic event, the Medical		19e. Informent's Neme/Reletionship	(Type, Print)	19b. A	Jeiling Address	(Street end Number o	r Rural Route Numb	er, City or Town, St	ate, Zip Code)
or tr		Alan L. Monte-Gi	ciffo			1 Ct., Coc	keysville	, MD 2103	30
to to	2	20a. Method of Disposition 1 Burial 2 □ Cremation 3	□Removel from State	20b. Plece of D cemetery,	isposition (Nar cremetory or o	ne of ther plece)	Date	20c. Location - Ci	ty or Town, State
iry or		4 □ Donation 5 □ Other (Spec				Mem.Gard.	Feb. 2. 19	98 Timor	ium, MD
Important: If Item 27 any injury or other tr once.		21. Signeture of Funerel Service Lic		Duraney		d Address of FecilityL			
any ir		Victor Les	igrand &	2.		adonia Rd.			
	+	23e. Pert1. Enter the disease, or co							Approximete Intervel Between
ician dical niner		Immediate Ceuse (Finei diseese or condition resulting in death)	. Metas	tatic C Due to (or es e con	Olon insequence of):	Cance)		30 yes
i Examiner		Sequenticity list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury	6	Due to (or es e cor	nsequence of):				
	1	thet initieted events	0.	Due to (or es e cor	nsequence of):				
se es the bu		resulting In death) Lest	d						
		resulting In death) Lest	d						
for use e		Pert II. Other significent conditions		ut not resulting in th	he underlying c	euse given In Pert I.	23b. Did	tobacco use contr	ibuta to the cause of d
gned by the enending be detached for use e by Physician/M	F			ut not resulting in t	he underlying c	euse given In Pert I.			
ugned by the entending be detached for use e by Physician/M	F F			ut not resulting in ti	he underlying c	euse given in Pert I.	1 🗆	Yes 2□No 3	24b. Were eutopsy findi eveileble prior to completion of ceus
nas been signed by the ettending 3e 2 should be detached for use employed by Physician/Ma	F F			ut not resulting in the	he underlying c	euse given in Pert I.	1 □ 24e. Wes	Yes 2 □ No 3 s en eutopsy ormed?	Probably 4 Unit
age 2 should be detached for use expending	F Consideration	Pert II. Other significent conditions		ut not resulting in th	he underlying c		24e. Wes	Yes 2 No 3 s en eutopsy ormed? Yes 2 No	24b. Were eutopsy findi eveileble prior to completion of ceus
entineate has been signed by the enemoing sctor, page 2 should be detached for use e	F F	Pert II. Other significent conditions 25. Wes cese referred to medical examiner?	contributing to death b			26. Plece of	24e. Wes pert	Yes 2 No 3 s en eutopsy ormed? Yes 2 No one)	24b. Were eutopsy find eveileble prior to completion of ceus of deeth? 1 Yes 2 No
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rector: After this certificate has been signed by the estending in by the funeral director, page 2 should be detached for use estimated.	F - 2	25. Wes cese referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 1 Netural 5 Pending	Hospitel: 1 inpatie 28a. Dete of inju (Month, Da) on be d 28e. Piece of Inju	ent 2□ER/Outp	ne of 2	26. Plece of Other: 4 Nursin 8c. Injury et Work? 1 Yes 2 No	24e. West perful to the perful	Yes 2 No 3 s en eutopsy ormed? Yes 2 No one) idence 6 MOther how Injury occurred	Probably 4 Unit 24b. Were eutopsy findi eveileble prior to completion of ceus of deeth? 1 □ Yes 2 No (Specify) Hospie
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ins certificate has been signed by the ettending all director, page 2 should be detached for use e	F	25. Wes cese referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 1 Netural Investigati 3 Suicide 6 Could not determine 29a. Certifier (Check only 2 Medical Examiner) 21 Medical Examiner	Hospitel: 1 inpatie 28a. Dete of Inju (Month, Da) 28e. Plece of Inju be do b	ant 2 ER/Outputry y Year) 28b. Time Injutry - At home, farm c. (Specify)	ne of 2 ury M 2 not street, factory deeth occurred or investigation.	26. Plece of OA Other: 4 Nursin Nursin Nork? 1 Yes 2 No /, office	24e. West pert 1 Deeth (Check only) 1 Best Pert 28d. Describe 28f. Location City or To	Yes 2 No 3 s en eutopsy ormed? Yes 2 No one) idence 6 XOther how injury occurred (Street end Number wn, State)	Probably 4 Unit 24b. Were eutopsy findice eveileble prior to completion of ceus of deeth? 1 Yes 2 No (Specify) HOSpic or Rurel Route Number, ter es steted. d due to the ceuse(s) Month, Dey, Yeer)
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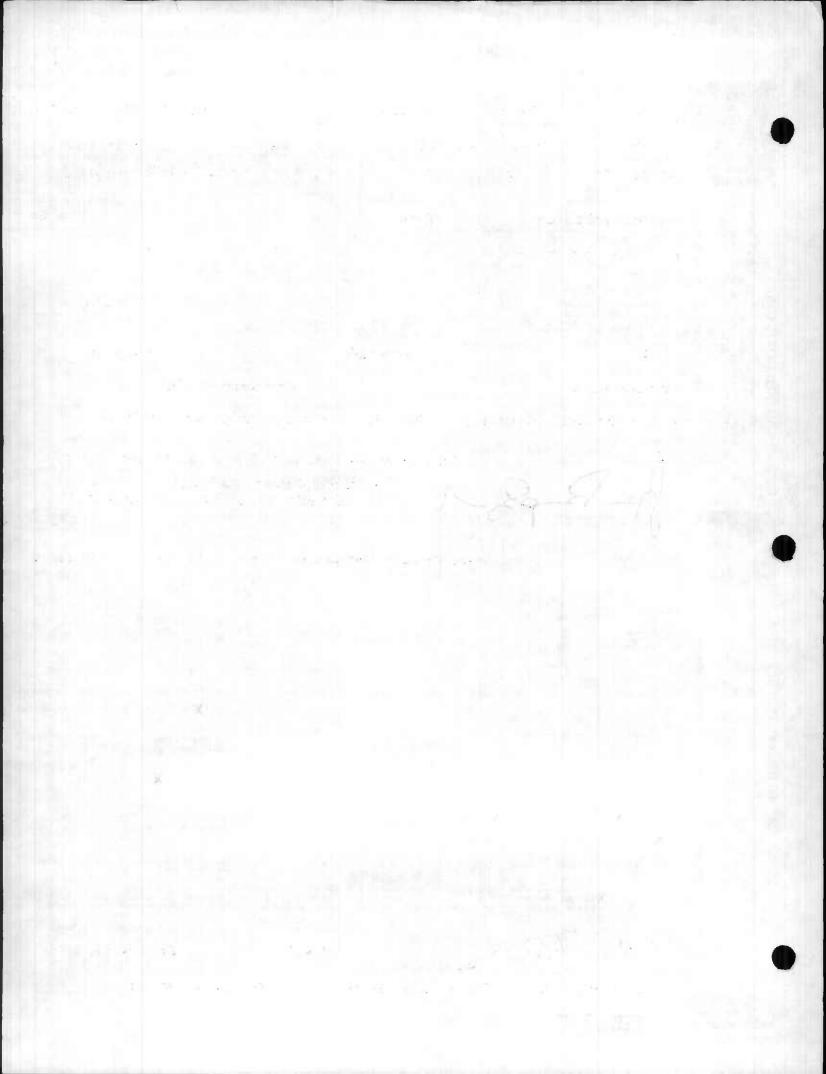


		State of M		epartment of Certificate o			gienej g	02	981				
	1. Decedent's Name (First, Midd	lle, Last)				2. Dete of Dee		Yeer	3. Time of Death				
Physician /Medical =	Mary	Irene	MCI	AIN		Januar	Day	1998	10:47 P.M				
	4a Fecility Name (If not institution				4b. City, Town, or I								
	Franklin S	quare Hospi	tal Cente	r	Rosed	la1e		Baltin	nore				
uneral	5. Social Security Number	6. Sex 7. A	ge (In yrs. lest birt	hday) If Under 1 Ye	ar if Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 9. E OCt. 20, 1928 Ma			ece (Stete or Foreign				
	218 22 9789	1□M 2□F	69	rs.	110010	Oct. 2	ct. 20,1928 Ma		land				
-	Usuel Residence of Decedent 10a. Stete 10b. County	,	10c. City, Town	or Location				10	d. inside City Limits				
2 .	Maryland Balti		Ess					1 □ Y					
or 28a-f sho e nout ed Director	10e. Street end Number	IOLE	Los				10g. Citizen of	M/hot Count					
0 2 0	1612 Riverwood	Poad		10f. Zip Code	21221		US		, , ,				
by Funeral Director	11. Maritel Status	12. Was Decedent	Ever in II S	13 Was Decedent of		pacify Vas or Na			n indien				
5	1 Never Merried 2 Ma	Armed Forces	?	If Yes, specify C	f Hispenic Origin? (S uban, Mexican, Puert								
0 0	3 ₩idowed 4 Divorce	if Yes Give		1□ Yes 2⊠N	lo Specify:		Specif	Whit	e				
natural',	15. Decede	nt's Education	16a.	Decedent's Usual Occ	cupation		16b. Kind of 8						
	(Specify only higher Elementery/Secondary (0-12)	est grade completed) College (1-4or	5+)	(Give kind of work do life. DO NOT use ret	ne during most of woi ired)	rking							
E O	12		H	ousewife			Ov	n hom	e				
other than natural sevent, the Medical Be Completed		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) JOSE						ne)					
TO T	John Schwensen				Josep	hine Bi	.ebel						
t: if item 27 is may y or other traum	19e. Informant's Name/Relation Jo Ann McDouga	, Stete, Zip (21234	Code)										
	20a. Method of Disposition	Surial 2 Cremetics 3 Demove from State cemetery, cremetory or other place)											
	Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. Gard. 2/3/98 Baltimore County, Md												
Important: any injury pnce.	Dulaney Valley Mem. Gard.2/3/98 Baltimore County, Md 22. Name and Address of Eacility Bruzdzinski Funeral Home PA												
Impor any ir ance.	Mrs 12	2	1	1				S back	1221				
	23a Fa 1. Enter the disease, o	r complications that chuse	ed the deeth. Do n		Eastern A			Land 2	Approximete				
oloion III	dck, or heert feilure. Lis	r complications that cause t only one cause on eech	line.		,,g, 02011 00 021 012				Interval Between Onset and Death				
rsician ledical	Immediate Cause (Final	William South	20, 11					1					
	disease or condition resulting in death)	e End St	- 0	nic Obstru	ctive Puln	nonary D	isease	1	30 Years				
5			Due to (or es a o	onsequence of):				ţ					
n end iel-transit Examiner	Sequentially list conditions	b	Due to (or as a c	onsequence of).									
bunel-trans	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury												
80 0	thet initieted events	C	Due to (or as e o	onsequence of):	-								
Wedi	resulting in death) Lest			7 1 1				1					
ettending p		d						1					
the ett hed fo	Part ii. Other significant conditi	ons contributing to death	but not resulting in	the underlying cause	given in Part i.	23b. Did	tobacco use co	ontributa to	the cause of death?				
ed by the deteched						1)0	Yes 2□ No	3 Prob	ebly 4 Unknown				
be de													
ate has been signed by the ettending ph. page 2 should be deteched for use as the completed by Physician/Med							en eutopsy rmed?	ava	re eutopsy findings illable prior to				
2 sh								of o	npletion of cause death?				
page 2						101	Yes 2 No	1 🗆	Yes 2□ No				
	25. Was case referred to medica examiner?	at l			26. Piece of De	ath (Check only o	one)						
0 D	examiner/ 1 ☐ Yes 2 💢 No	Hospital:	ient 2 ER/Out	patient 3 DOA	Other: 4 Nursing H	lome 5 Resid	dence 6 🗆 Ot	her (Specify)				
	27. Manner of Death 1 XNeturel 5 ☐ Pendi	28a. Date of Inj		ime of 28c. In	njury et Vork?	28d. Describe I	how injury occu	rred					
the fur	2 ☐ Accident invest	igation			☐ Yes 2 ☐ No								
To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could deten	nined 286. Place of it	njury - At home, fai etc. (Specify)	m, street, factory, office	се	28f. Location (3 City or Tox	Street end Num vn, Stete)	ber or Rurel	Route Number,				
completely filled in by													
ical	(Check only 2 Medica	ng Physician: To the best Examiner: On the basis	of examination end	death occurred et the	time, dete end plece y opinion, death occu	e, end due to the arred et the time.	ceuse(s) end m	enner es sta , and due to	ated. the ceuse(s)				
on the Funer Impletely fill Medical	one)	and manner s	tated.										
0 00	29b. Signature end title of confident 29c. License number						29d. Dete signed (Month, Dey, Year)						
		11 // //		D	January 30, 1998								

State Registrar Marie Chatham M.D.
31. Date filed (Month, Dey, Year) FEB 0 3 1998

9000 Franklin Square Drive
32 Registrar's Signature Die Davidson-Randale

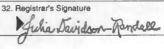
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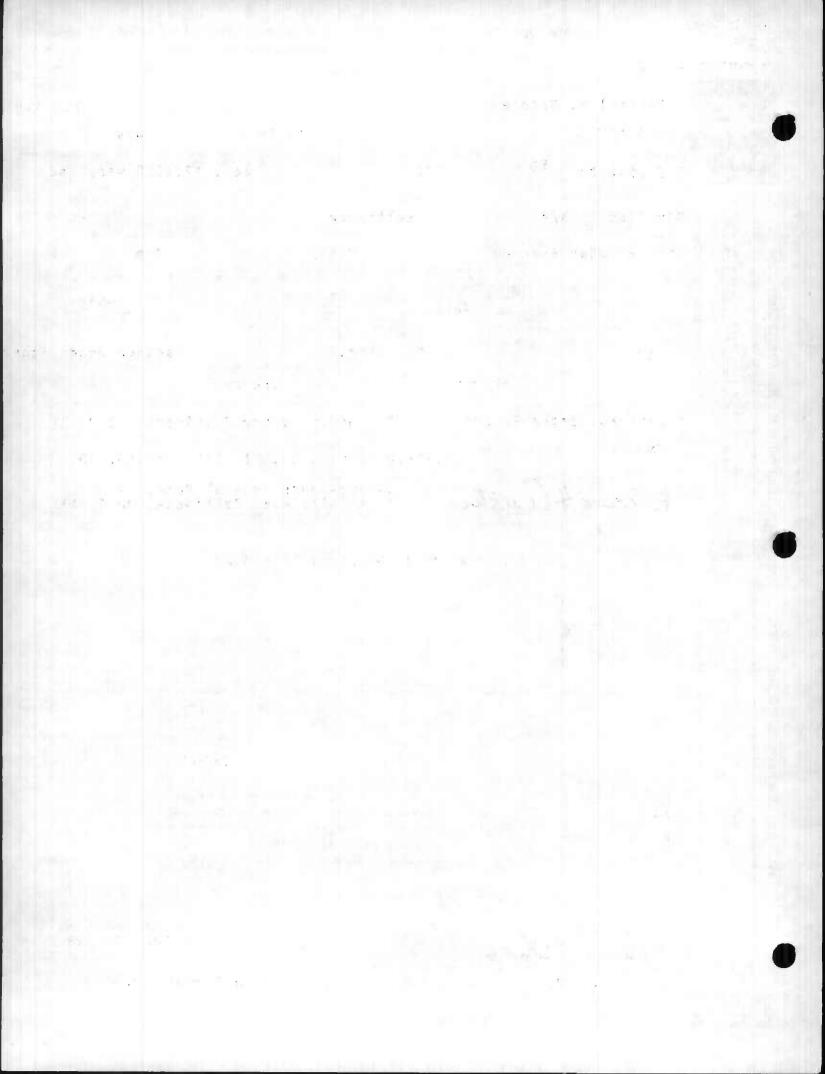


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CZ	ARROLL F.	MARBLE	Otate of Marylar	Certific				Reg. No.	02	982
	DIA 11	1. Decedent's Name (First, Middle, Las					2. Data of Dec		Year	3. Time of Death
	Physician /Medical	Carroll F. Ma					JAN.	23, 199	8	3:22 AM
	Examiner	4a Facility Name (If not institution, give 2609 HAMPDEN	e street and number)			4b. City, Town, or L BALTIMO	RE	N	/ A	
	Funeral Director	212-20-0627	ex ☐XM 2□ F	7 2 Yrs. If U	nder 1 Year ths Days	If Undar 24 Hrs. Hours Min.	8. Data of Bird (Month, Da Feb. 1	7,1925	9. Birthpl Count Mar	ace (State or Foreign lry) yland
	Dw Dw	Usuat Residence of Decedent 10a. Stata 10b. County	10c. Ci	ty, Town or Location					10	d. Inside City Limits
	Many Ff sh	Maryland N/A	4	Balti	more					X□XYas 2□No
	ath with the Marylan 23s or 28s-f show	10e. Street and Number		10f	. Zip Code			10g. Citizen of V	/hat Coun	try?
	ath w	2609 Hampden Av			2121			USA		
020	n 72 hours efter death with the Maryland "natural", or items 23s or 28s-f show added Examinet must be notified at leted by Funeral Director	3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever In U Armed Forces? 1 M Yas 2 No If Yes, Give Year or Dates: WW I		ecedent of F specity Cuba es 2 10 100	dispento Origin? (Span, Mexican, Puerto Specify:	ecity Yas or No Rican, etc.)	Specify	e - America k, White, a	
Baltimore, Maryland 21215-0020	ed within 72 hor bygiene. The Med call ft, me Wed call Completed	15. Decedent's Ed (Specify only highest gra	ucetion	16e. Decedent's	Usual Occup	eation during most of work	dna	16b. Kind of Bu	siness/Ind	lustry
121	than "r	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work d)	9	Develop		
d 2		1 Z 17. Father's Name (First, Middle, Last)		CI	erk	18. Mother's Nam	e (First, Middle,		-	oods Stor
lan	Se se se		Unknown				nown			
ary	should and Men a marke numatic	19a. Informant's Name/Relationship (7		19b. Mailing Add	dress (Street	and Number or Rui	ral Route Number	er, City or Town,	Stata, Zip	Code)
, N	and 2 ealth n 27 i	Albert Ballinge				n Avenu				
ore	H less to the second	20a. Method of Disposition 1X Surial 2 □ Cramation 3 □	memoval from State	Place of Disposition cemetery, crematory			Date	20c. Location -	,	
H	it. Pa	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Ligen		illtop S		e CO.	1/29/9	8 Tows	on,	MU
	Physician /Medical Examiner	23a Part Enter the character of companies, or companies List only of the character of the c	a Arterioscle		diovas			rrest,		Approximate Intervel Between Onset and Death
	executed in end ial-transit		b		-0				-	
oʻ	execution and high-tra	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	01):				t	
x 68760,	entificate be executed ding physicien and se as the bunal-transit	Cause (Disease or injury that initiated events resulting in death) Last	C. Dua to (d	or as a consequanca	of):				1	S/T-FI
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of Vital Records,	D 2s						perfo	an autopsy ormed? ECTION	coi	ere autopsy findings eilable prior to appletion of ceuse death?
al R	cate he						10	Yes 2 No	10	Yas 2 No
Vit.	Physician: The this certificate ral director, page To Be Co	25. Was cese referred to medicat examiner?	Hospitat:	3	Ott	26. Place of Dee			10 11	
	r this c eral dire	27. Manner of Death	28a. Dete of Injury (Month, Day Yaar)	28b. Time of	28c. Inju	4 U Nursing H		dence 6 □Oth how Injury occur		/)
ion	Attending F or deeth. ector: After by the funerilfication:	1XXNatural 5 ☐ Pending 2 ☐ Accident investigation		Injury M		rk? Yas 2□No				
Division	P4 2 2	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, street, fa	ctory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rura	l Route Number,
	Hospi 14 hour Funer tely fill		me, date end place opinion, death occur							
	To the comple	29b. Signature and title of certifier	Pude so		29c. Licens	.C.M.E		JAN.		
	TX,	30. Name and eddress of person who of Dennis Chute M.I		m 23a) (Type, Print) 11 Penn S	treet	, Baltimo	re, Mar	yland 21	201	
	Fx,				treet	, Baltimo	re, Mar	yland 21	201	

Registrar





Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Edwin Robert Moats January 19 1998 9:15 PM 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Homewood at Williamsport Williamsport
r If Undar 24 Hr 8. Do
Hours Min (N Washington If Under 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Days Months 1 XM 2 □ F Yrs 577-07-0353 89 November 12,1908 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Washington Williamsport 10a. Street and Number 10f. Zlp Code 10g. Citizan of What Country? 16505 Virginia Avenue 21795-1399 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Yaar or Datas; 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usuai Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) 8 Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumame) Dallas Moats Alice McLucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Carrie Moats/Wife 8712 Slabtown Road Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 1/22/98 Hancock, MD Stone Bridge Brethren 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Grove Funeral Home, P.A. P.O.Box 368 Hancock, MD 21750-0368 23a. Part1. Entar tha disease, or colorshock, or heart failure. List only that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Immediata Cause (Final disaase or condition resulting in death) THOKE Due to (or as a consequence of): TEMOSCUMOSIS Dua to (or as a consequence of):

Physician /Medical Examiner

certificate be

Division of Vital Records, P.O.

mportant: If Item 27

injury or

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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r then "netural", or items 23s or 28s-f show the Medical Examiner must be notified at

al Hyglene.

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Pages 1

Examiner physician end the burial-transit an/Medical SE for use as Physici detached signed by i 2 Completed s certificate hes b director, Be 10 funerai Certification:

been

death.

efter death Director: /

To the Hospital within 24 hours a To the Funeral Completely filled

Sequentially list conditions, if any, leading to immadiate cause. Enter Undarfying Cause (Disease or injury that initiated events resulting in death) Lest

Due to (or as a consequence of):

Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings avellabla prior to completion of cause of death? 24a. Was an autopsy 28 M

1 ☐ Yes 26. Placa of Death (Check only ona)

1 ☐ Yas 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation

6 ☐ Could not be datarmined

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1☐Yes 2☐No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

29a. Certifier (Check only

1 BNatural

2 Accidant

3 Suicide

4 Homicide

1 🗀 cartifying Physicien: To tha best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner stated.

29b. Signature a

29d. Data signed (Month, Dey, Year)

28f. Location (Straet end Number or Rural Routa Number, City or Town, Stete)

30. Name and address of person

EDICUAL Maccon tho completed causa of death (Item 23a) (Type, Print)

Hospital:

STEPHEN

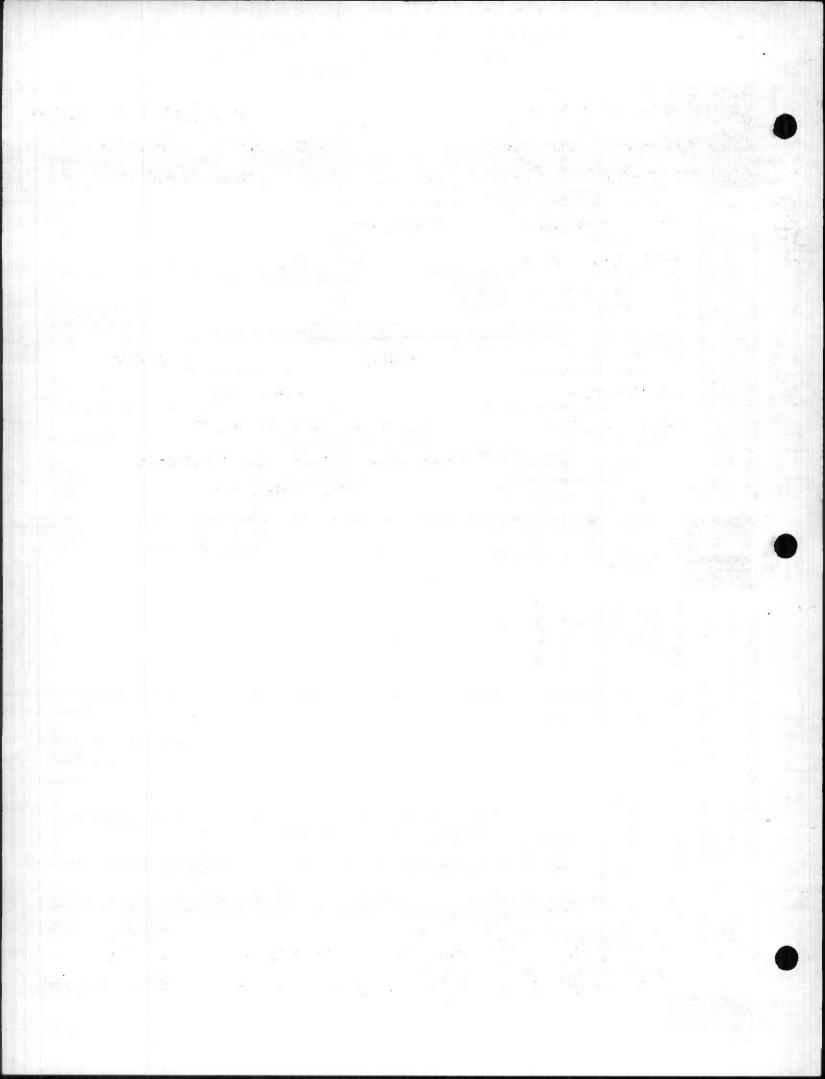
31. Data filad (Month, Day, Year) 0 3 1998 FEB

32 Registrar's Signature

Mia Davidson

Registrar

Medical



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Amy M. Moore January 29,1998 1620 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Anne Arundel Medical Center Annapolis Ar

If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) Anne Arundel If Under 1 Yeer Montha Deya 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Montha 1 M 2 TF 118-16-1204 Director 98 Aug. 31, 1899 Massachusetts Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Exprines must be motified at once. 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Annapolis Director 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3132 Catrina Lane 21403 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: þ Specify: White 3 □ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Industry Elementary/Secondery (0-12) College (1-4or 5+) Care Giver Health Care 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Melden Sumeme) Be Charles Myers Mary Flemming 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Beverly Linkins-Daughter 3132 Catrina Lane, Annapolis, MD 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Metro Crematory 2/2 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. Womes 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complicationa thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. Approximete Intervai Batween **Physician** /Medical immediate Ceuse (Final · Cardiac Arrest hour 40 minutes diseese or condition resulting in deeth) Examiner i hour and Physician/Medical Examiner Electromechaniol dissociation entricular tachycardia physician and the burial-transit The lew requires that the death certificate to executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last My o cardial

Due to (or as e consequence of): Infarction Division of Vital Records, P.O. Box 68760, Artery Direarc eronory signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Brain A 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24a. Was an autopsy performed? s certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ FP/Outpatient 3 ☐ DOA 1 Yes 2 Othar: 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Maturai 5 ☐ Pending after death. Director: Aft 1□Yes 2□No 2 Accident Investigation 6 Could not be datarminad 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida 24 hours a To the Hosp within 24 hor To the Fune completely fi 29a. Certifian 1 Cartifying Physician: To the best of my knowledge, daeth occurred at tha time, data end place, end due to the ceusa(s) and menner as steted. 2 Medical Examiner: On the basic of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of cen 29c. License number 29d. Date signed (Month, Dey, Year) 1)32654 January 29, 1998 10 on who completed causa of daath (item 23a) (Type, Print) Serlemitros John C. 1509 Ritchie Highway, Arnold, MD 21012

DHMH 16 Rev 6/95

State

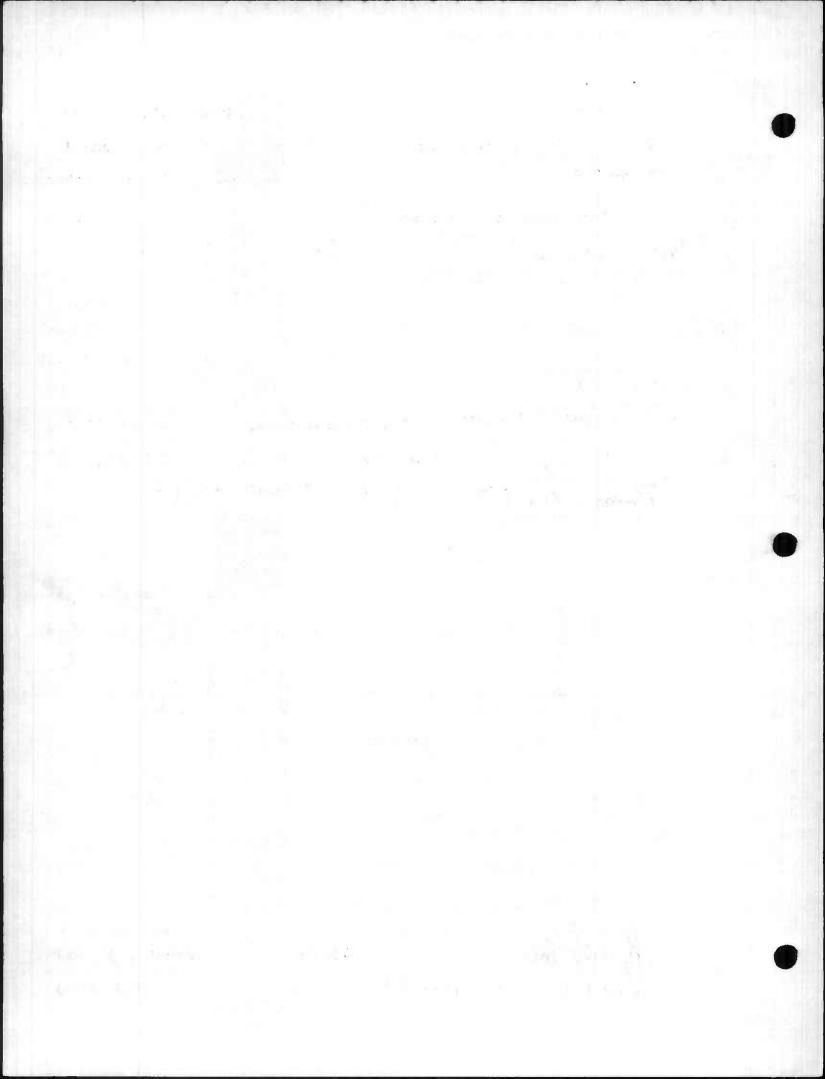
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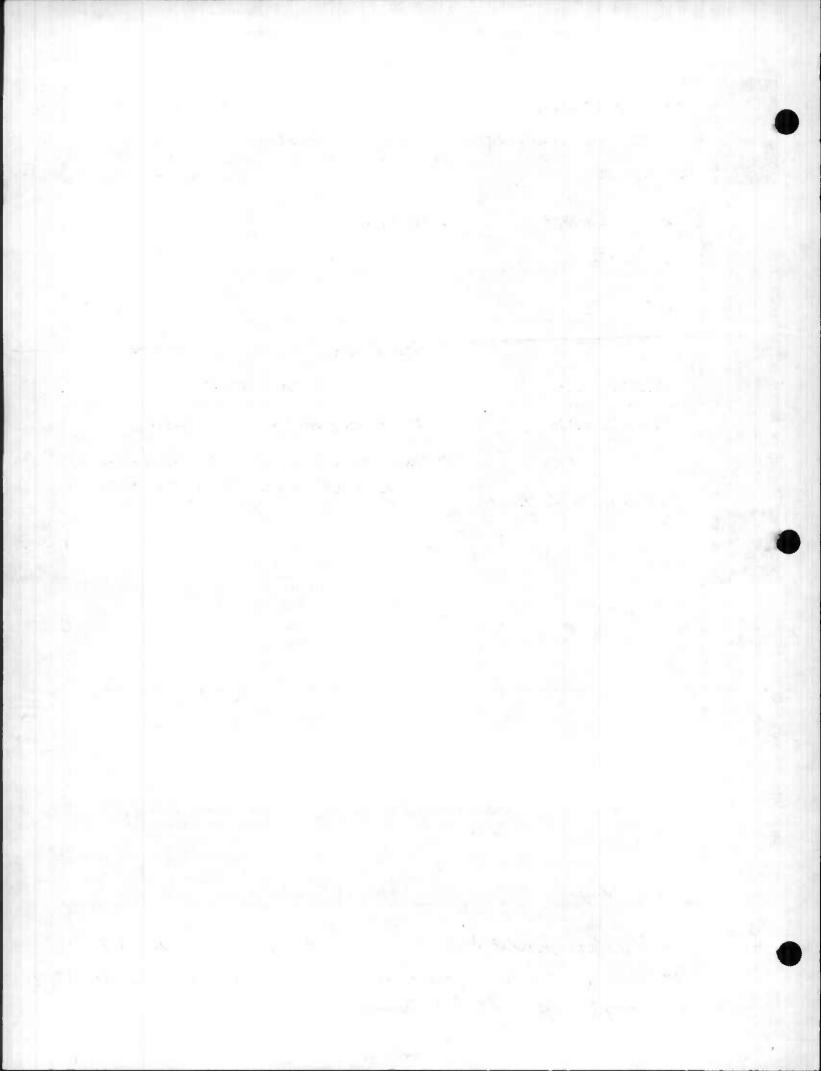
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32. Registrar's Signeture

Julia Davidson

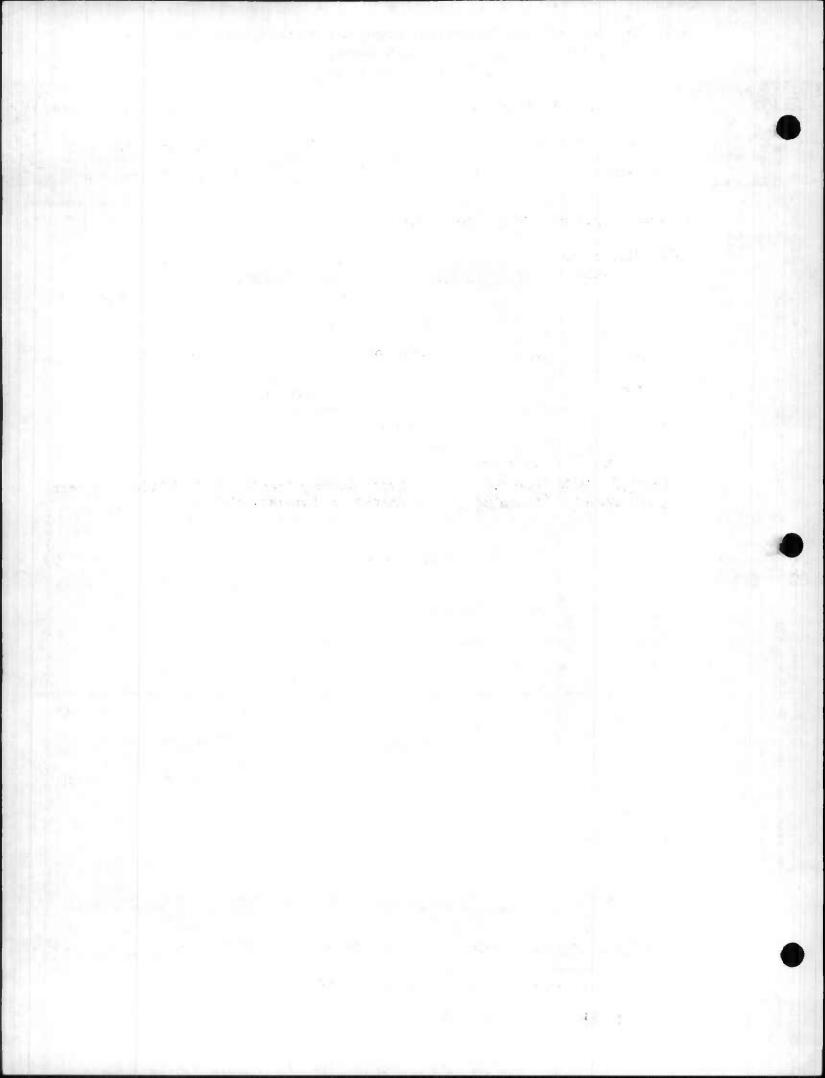


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al	5	. Sociel Security Number	6. Sex 7. Ag	ge (In yrs. las	M	f Under 1 Yeer lonths Deys			th ey, Year)	9. Birthp	lece (Stete or For
r		236-62-5822 Usuel Residence of Decedent	VE III ZEIT	54	Yrs.				2, 1944		T VIRGIN
	-	0a. State 10b. County		10c. City, 7	Town or Locati	ion				1	0d. inside City Lin
0		WV BERKE	TEV	HED	GESVILI	F					1 ☐ Yes 2 ☐
Director	1	Oe. Street end Number	пот	пы		10f. Zip Code			10g. Citizen of N	Whet Coun	itry?
		PO BOX 652				25427			U.S.A		
Funeral	1	1. Meritel Status	12. Wes Decedent	Ever in U,S.	13. Wes		Hispanic Origin? (Specify Yes or No rto Rican, etc.)		e - Americ	
þ		1 Never Merried 2 Marr 3 Widowed 4 Divorced	If Yes Give A			es, specify Cub Yes 2□ No		rto Rican, etc.)	Specify	ck, White, y: WHI	
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	-	4 Donetion 5 Other (S		ROS		CEMETER		1-28-98	MARTIN	SBURG	, WV
	2	21. Signeture of Funerel Service	M Bus	/74 /	BRO		ERAL HOM	E, 327 W			Т,
3	1	23a. Pert1. Enter the disease, or shock, or heert feilure. List	complications that caused only one cause on each li	d the death.	Do not enter the	ne mode of dyi	ng, such es cardia	ac or respiretory e	rrest,		Approximete Intervel Between
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L	C	mmediate Ceuse (Finel liseese or condition esuiting in deeth)	6.	Mer	non	a.					week.
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cia	P	ert II. Other significent condition	no contributing to death b	ut not recultir	a in the under	chulana anuna ain	on in Bort I	. Josh Did	tobecco use co	ménihuén én	the course of day
Physician/M		ort ii. Other significant conduct	Vie contributing to death b	ot not resulti	ig in the orige	nying cause giv	ven in Pen I.		Yes 2 No		the cause of dec pably 4 Unkn
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e Completed		5. Wes case referred to medical				3 DOA Ott	or /	Home 5 ☐ Resi		er (Specify	()
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State of Maryland / Department of Health and Mental Hygiene 9 8 0 2 9 8

					Certi	ficate of	Death		Reg. No.	1 0	470) ()
DI1-1		1. Decedent's Neme (First, Middle, Las						2. Dete of D	eath	Vass	3. Time	of Death
Physici /Medi		PATRICIA A	MARTIN					Janua,	ry 25	Year 1998	2.	AM
Examir		4a. Facility Neme (If not institution, give					4b. City, Town, or			of Death		
<u>. </u>		Sinai Hosp						nove Ci		imore	Cit	У
Funeral Director		212 42 0005	7. Age (In yrs			Under 1 Yeer Ionths Days			irth Pay, Year) 24, 1943		lace (Stat	te or Foreig
pu k		Usual Residence of Decedent 10a. State 10b. County	100.0	ih. Tour	or Locat	ion				14		
the Marylar 28a-f show	ž					ion				10		City Limit es 2 □ N
28a-f	ect	Maryland Baltimon	te city bar	timo		101 7:- 0-1-						20 2
23a or	Funeral Director	4702 Pimlico Road				10f. Zip Code 21215			U.S.A.	What Count	ry?	
or its	by	11. Marital Status Unknown 1 □ Never Merried 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Amed Forces? unk; 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates:	u,s. nown		S Decedent of less, specify Cub	Hispanic Origin? (S ben, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		ca - America ck, White, e v: Blac	etc.	
72 h	etec	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a.	Decedeni	's Usual Occu	pation during most of wo	ndkina	16b. Kind of B	usiness/ind	ustry	
within and the control of the contro	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO	NOT use retire	ed)	rang	unknow	n		
Hygie Ther		unknown 17. Father's Name (First, Middle, Last)	unknown	4.	.1101104	ATI	19. Mothodo No	ma /Eirat Middle	e, Maiden Suman			
ntal n	Be	unknown						me (rirst, Middi	e, maioen suman	10)		
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end z si salth end 1 27 la n er traur		19a. Informant's Name/Relationship (T) unknown	ype, Print)		inkno		t and Number or R	ural Route Numi	ber, City or Town,	State, Zip	Code)	
permit. Peges 1 and 2 should be filed within 72 hours beatment of Health and Mental Hygiane. Important: If Item 27 is merked other than "natural, any injury or other traumatic event, its Medical Exp		20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ I 4 □ Donation 5 ☒ Other (Specify,	Removal from State	Place of cemetery	/, cremate	on (Name of ory or other pla		Dete	20c. Location -			
Departition of the control of the co		21. Signature of Fyngral Service Licens Ronal d S Wade,	Director		Sta Bal	ame and Addr te Ana timore	ess of Facility tomy Boar , Marylar	d, 655	W. Balti	more	Stre	et
hysician		23a. Patt. Enter the disease, or comp sheck, or heart failure. List only of	lications that caused the deane cause on each line.	ith. Do n			, ,				Approxim interval B Onsel an	Between
/Medicai		immediate Cause (Final disease or condition	-	Phell	mon	10					ila	ans
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5 0 6	Medical	Ceuse (Disease or Injury that initiated events resulting in deeth) Last	Due to (or as e co	onsequen	ce of):						
ath co	Physician/									1		
the a	/sic	Pert il. Other stgniftcant conditions co	ntributing to deeth but not re	sulting in	the unde	rlying cause gi	iven in Part I.	23b. Dio	i tobacco use co	ntribute to	the caus	e of deat
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aw requir s been s 2 should	Completed							24a, Wa perl	s en eutopsy formed?	con	re autops ilable pric npletion o death?	
The law ate hes b page 2 s	PO.							1 🗆	Yes 2 No	1 🗆	Yes 2	No
	Be	25. Was case referred to medical					26. Place of De	eth (Check only	one)			
rhysician: this certific ral director,	10	exeminer?	Hospital: 1 inpatient 2	ER/Out	patient	3□ DOA OI	her: 4 Nursing I	Home 5 🗆 Res	idence 6 Doth	er (Specify	,)	
£ 76		27. Menner of Death	28a. Date of tnjury (Month, Day Year)	28b. Ti		28c. inju		1	how injury occur			
death. tor: Aft the fur	catio	1 Anaturei 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				M 1	Yes 2□No	COM Leasting	(0)		(Davida A)	
ins after al Direction by	Certification:	28e. Placa of injury - At home, farm, street, fectory, office building, etc. (Specify) 28e. Placa of injury - At home, farm, street, fectory, office building, etc. (Specify)								House M	imber,	
to the mospital or arending the within 2 Hours after death. To the Funeral Director. After this completely filled in by the funeral	Medicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knoner: On the basis of examinand manner stated.	owledge, ation and	deeth oc Vor invest	curred at the ti igation, in my	ime, date and place opinion, death occur	e, end due to the urred at the time	ceuse(s) and ma , date and place,	inner as sta end due to	ated. the cause	ə(s)
Withi Com	Σ	29b. Signeture end title of certifier				29c. Licen			29d. Date signe	d (Month, E	Day, Year)
		Marti Ba	·				102321	HB9517	Janua	ry 2:	5, 1	998
		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (7	Type, Prin	nt)	, 0					
		HARSHI 13	AINS, Sino	al	HOSI	oital c	of Bal	timore				
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	O	00							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 2987 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death Ella **Physician** Nora Ogle Month 1815 February 01 1998 /Medical 4a. Fecility Nema (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE BALTIMORE SAINT AGNES 7. Age (In yrs. lest birthday)
Rough | Months | Days | Hours | Min. | Min. | Month | Day | Hours | Min. | March | March | 1915 | Virginia 5. Social Security Number **Funeral** 1□ M 2⊠ F 215-01-5938 Director Usual Residence of Decadent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Ellicott City 1 Yas X No Director Howard Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 21042 3612 Scheel Drive United States Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 2 should be filled within 72 hours efter on and Mentel Hyglene.

Is marked other than "natural", or ite. 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas: 1 Never Married 2 Married 1 Yas 2 No Specify: Specify þ 3₺ Widowad 4 Divorced White Completed traumatic event, the Medical 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Housewife Own Home 8 Years 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) William I. Burton Blanche A. Fugua 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 end 2.
Department of Health er
Important: if Itam 27 is
any injury or other trau 3612 Scheel Drive Ellicott City, MD Mr. George W. Ogle, Jr./Son 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20c. Location - City or Town, State TD Burial 2 Cremetion 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacity) Oak Lawn Cemetery 2/4/1998 Baltimore, Maryland 21. Signature of Faheral Service Licensee 22. Nama and Addrass of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that causad tha deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or haart fallow. List only one causa on each line. Approximate Interval Batwean Onset and Death **Physician** /Medical Immediata Causa (Final BILATERAL PNEUMONIA diseasa or condition rasulting in daath) Examiner CONGESTIVE HEART FAILURE Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaasa or injury that initialed avants resulting in death) Lest Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? CEREBRO VAS CULAD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown by 24b. Wara eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ACCIDENT Completed 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axaminer? Be 28. Place of Death (Chack only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 1 Yas 2 No 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No 2 ☐ Accidant invastigation 6 Could not be datamined 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

il or Attendin efter death. Director: Afi To the Hospital of within 24 hours of To the Funeral Discompletely filled I

29a. Certifian (Check only one) 29b. Signature end title of certifian

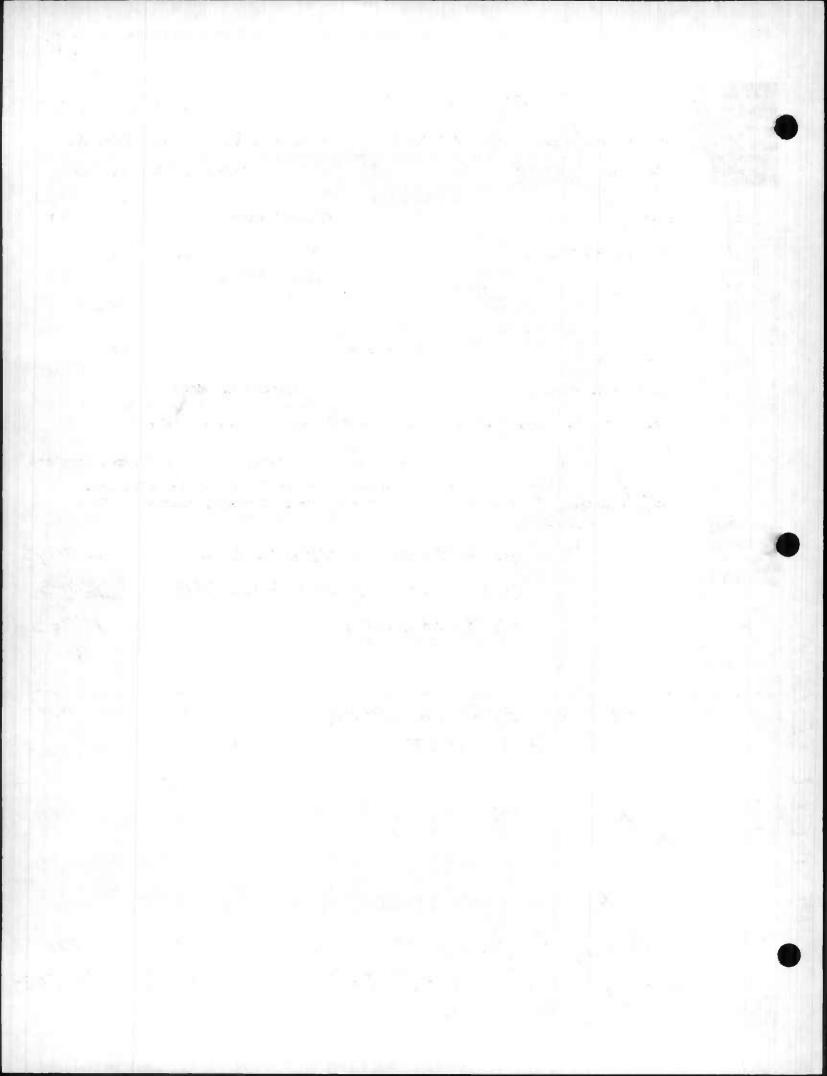
4 Homicida

12 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On tha basis of axamination end/or invastigation, in my opinion, death occurred at the time, date end place, and due to tha causa(s) end mannar stated. 29c. License number 29d. Data signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Rodney S. Iancovici MD, Stagnes Hospital, Balto MD 21229

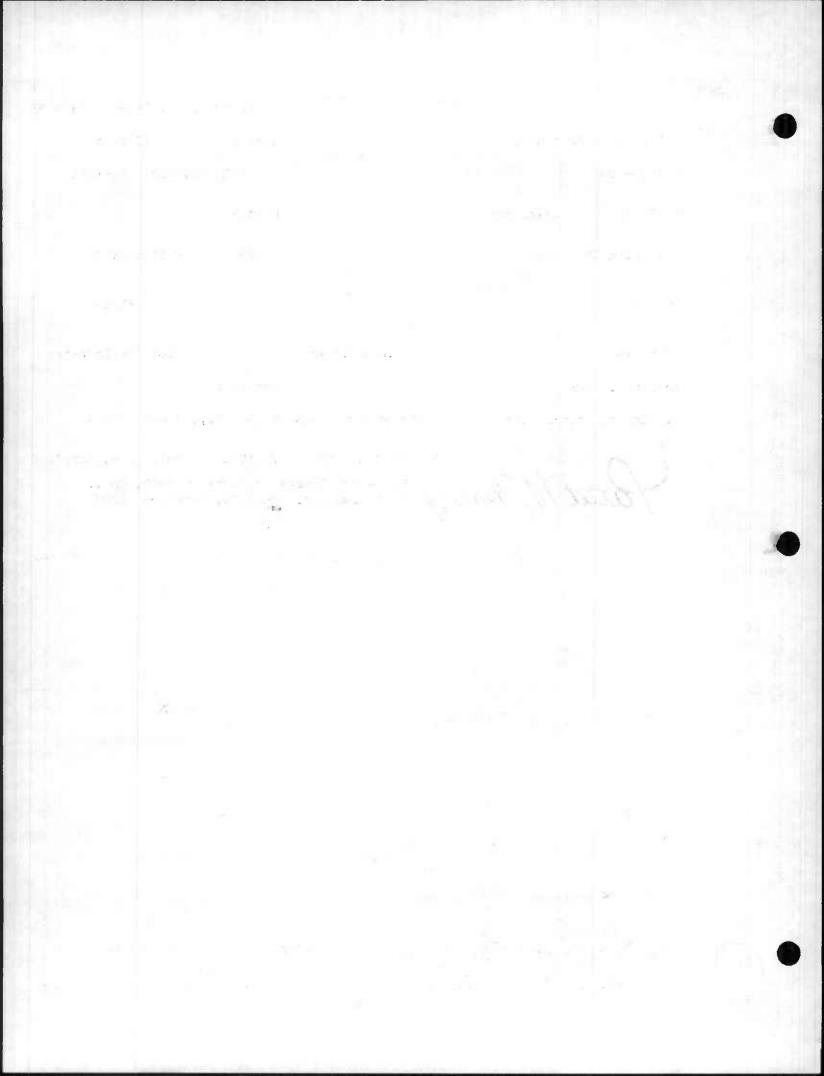
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Medical



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/Medic					Alice	2		Pip	oin	Month Februa	ry 2, 1	Yeer 998	3:45 A
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		1927 Dunda]			0 . //.		If Under	1 Vans	Duno	dalk		ltimor	
uneral rector		5. Social Security Numbar 257-24-6892 Usual Residence of Decedent	6. Şax	M 225 /.	84	lest birthday) Yrs.	Months	Deys	Hours Min.	8. Dete of Bird (Month, Da July 3	1,1913	9. Birthpia Countr Geor	ca (Stete or For y) cgia
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or items	by Funeral	11. Marital Status 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divorce	larried	2. Was Decede Armed Force 1 Yes 21 If Yes, Give Yaar or Dete	s? ☑ No		Was Daced f Yes, spec 1 ☐ Yes 2		ispenic Origin? (S in, Maxican, Puerl Specify:	pecify Yas or No o Ricen, etc.)		ce - Amarica ck, Whita, at White	tc.
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V =		R. Clayton Ma	artin	Son		421	Steve	ens I	Road Eag	gle Pt.,	.Oregon	9752	24
f itam 2 or other		20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetio	n 3 MBa	movel from Sta		Place of Dispos cemetery, crem	sition (Nem	ne of thar plac	e)	Date	20c. Location	City or Tow	m, State
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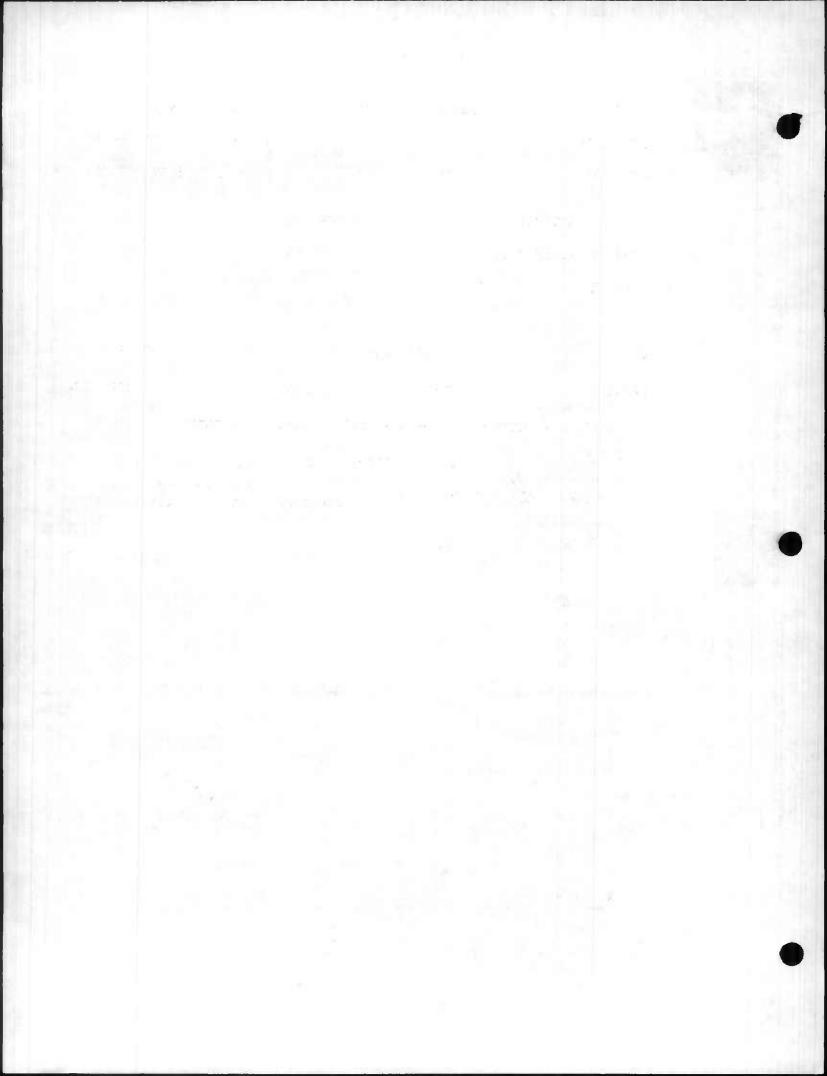


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2989

					Certifica	ite of	Death		Reg. No."	060	0)
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Exan	dical niner	4e. Fecility Neme (If not institution, g						, or Location of Deel		of Deeth	
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Funera	ai l			(In yrs. last birt		er 1 Year	if Under 24		rth	9. Birthplece (Stete or Foreign
Directo	_	219-32-5876 Usual Residence of Decedent	1□M 2XF	60	Yrs. Month	s Deys	Hours	FEB. 8	3, 1937	Country) `	MD
dand dand		10a. State 10b. County		10c. City, Town	n or Location					10d. Ins	side City Limits
the Merylan 28a-f show	Director	MD BAL'	TIMORE		401		SVILLE				Yes 🎾 No
ath with 23e or	rai Dir	7434 KATHYD	ALE ROAD		101. 2	ip Code	21208		10g. Citizen of \	U.S.A.	
21215-0020 3 within 72 hours after death with the Meryland jiene. Then "neturel", or items 23e or 28e-1 show the Medical Exercites must be notified as	by Funeral	11. Maritel Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Dates:		If Yes, sp	edent of Hoecify Cuba 2 No	lispenic Origin an, Mexican, P Specify:	? (Specify Yes or No ruerto Rican, etc.)	Blac	e - American Ind ck, White, etc. : WHITE	lien,
72 hours		15. Decedent's		16a.	Decedent's Us	sual Occup	ation		16b. Kind of B	usiness/Industry	
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aryla should and Men marks	10	HARRY 19e. Informent's Name/Relationship	(Tyme Print)		Mailing Addre	sec (Street		or Rurel Route Numb	ar City or Town		
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timer tmer tant		4 Donetion 5 Other (Spec	0	HILLI	OP SER			1/29/98	TOWSON	, MD	
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P.O hat the d by th	Physician	Total distribution continues	Contributing to death bu	it not resulting in	Title dilderlying	g cease giv	on in raiti.		Yes 2 No		4 Unknown
aw requir	Completed by							24e. Was	s en eutopsy ormed?	24b. Were eu eveileble completi of deeth	prior to on of ceuse
G 5 5 5	E							1 🗆	Yes 2 No	1 ☐ Yes	2 No
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of Vital Physician: T this certificat ral director, p	0	exeminer?	Hospital:	nt 2 ER/Ou	tpetient 3	DOA Oth	or	ng Home 5 A Res		er (Specify)	
T g b	tion: T	27. Manner of Deeth 1 Naturel 5 Pending 2 Accident Investigati	28a. Dete of Injur (Month, Dey		Fime of njury	28c. Injur Wor		28d. Describe	how Injury occur		
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Hospital 24 herds Funeral stely filled	edicai C	29a. Certifier (Check only one) 12 Certifying F	hyelcien: To the best of miner: On the basis of end menner ste	examination end	, death occurre d/or investigetion	ed et the tir on, in my o	ne, date end p pinion, deeth	plece, end due to the occurred et the time	cause(s) end me , dete end plece,	enner es steted. end due to the c	euse(s)
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o the to the bounded	Z	29b. Signature end title of certifier			2	9c. Licens	e number		29d. Date signe	d (Month, Day, 1	(ear)
To the Hospital or within 24 hours after To the Funeral Dir completely filled in		^	H (A		2	9c. Licens		<u></u>			(ear)
To the to within 2 To the complete		> matilda				9c. Licens	e number	20	1/28		(ear)
To the twithin 2 To the complete		^	completed cause of de	eeth (Item 23e) ((Type, Print)	D	262	VILLE, A	1/28	198	(ear)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death **Physician** Asswaters VOVMAN rugene 1108 JAN /Medicai 4b. City, Town, or Location of Death 4a. Fecility Neme (If not institution, give straat and number) OLEN BURNIE If Under 24 Hrs. 8 Der 4c. County of Death Examiner Bend (olen secret 5. Social Sacurity Number If Undar 1 Year 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1 M 2□ F Milford DE. 222 32 4596 Yrs. 50 Director 19/ Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show MD. Ann Arundel Glen Burnie rall, or items 23a or 28a-f si Examiner must be notitled M Yas 2 No Director 10e. Streef and Number 10f. Zip Coda 10g. Citizan of What Counfry? 403 F Secret Bend 21061 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indian, Black, White, atc. 11. Maritel Status 12 Yas 2 No If Yas, Giva Yaar or Datas: 1965-67 1 Never Marriad 200 Married "natural", or 1 ☐ Yas XXNo Specify: White by 3 ☐ Widowed 4 ☐ Divorced r than "nature Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Baltimore Gas Peges 1 end 2 should be filed within nent of Health and Mentel Hygiene. Int: If flem 27 is marked other than Iry or other traumatic event, me M Service Order Representative 12 & Electric Cd 17. Father's Neme (First, Middla, Last) 18. Mother's Nama (First, Middla, Malden Sumerna) Norman Eugene Passwaters Sr. Janette Laughery Passwaters 19a. Informant's Name/Relationship (Typa, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Donna L. Passwaters 1635 Severn Run Ct. Severn, MD. 21144 20b. Placa of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1⊠ Burial 2 □ Crametion 3 □ Ramoval from State permit. Pege Department of important: any injury o 4 ☐ Donetion 5 ☐ Othar (Specify) Odd Fellows Cemetery 1/24/98 Milford, DE.19963 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licensee McKnatt Funeral Home M00786 50 Commerce St. Harrington, DE. 19952 23a. Part 1. Entar tha disaasa, or complications that causad the deeth. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only ona causa on each line. **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in death) Examiner Physician/Medical Examiner Sequantially list conditions, if eny, leeding to immediate cause. Enter Undarlying Ceusa (Disaasa or Injury that initiated avants rasulting in death) Lest rrhosis, Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Wara autopsy findings evailabla prior to complation of causa of death? 24a. Was en eutopsy performed? 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No. 25. Was casa refarred to medical Be 26. Placa of Death (Check only one) examinar? 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidenca 6 □Other (Specify) 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mennar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Neturel 2 Accidant 5 Pending invastigation 1 ☐ Yas 2 ☐ No 6 Could not be 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

Box (P.O. Records. Vital 0 no

Baltimore, Maryland

4 Homicide Medicai 29a. Certifiar

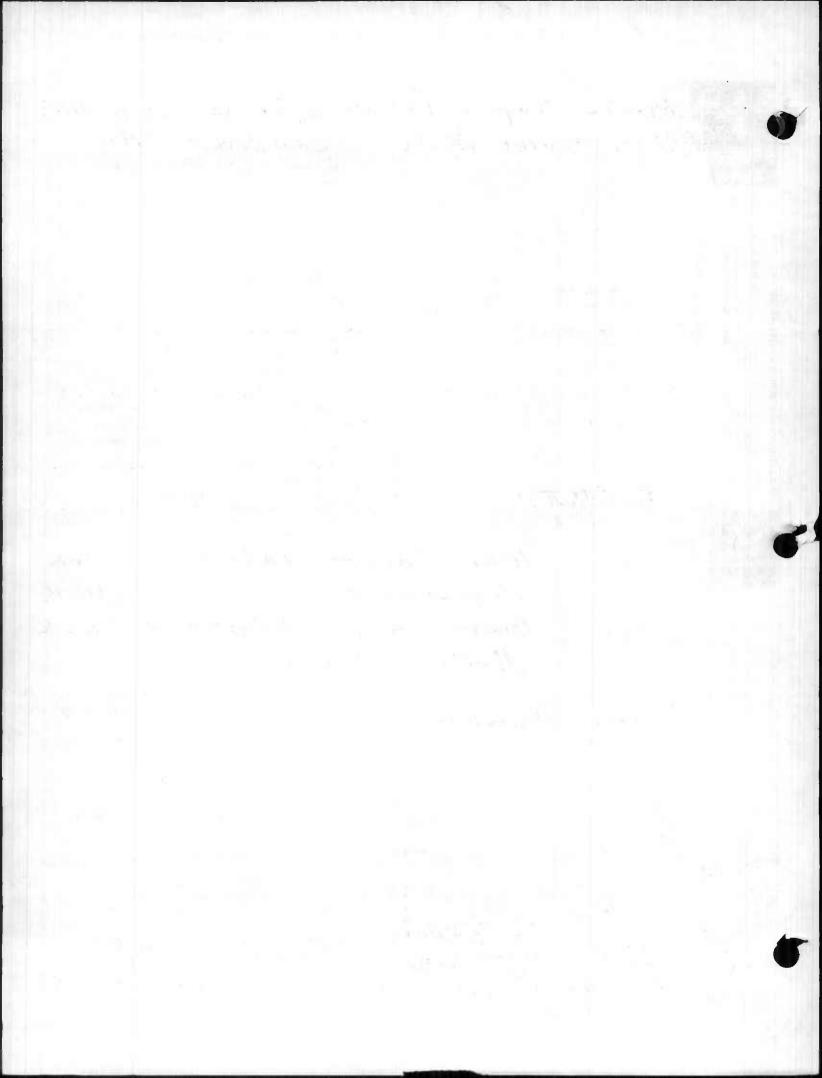
State Registrar Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end titla of cartifian

29c. Licansa number

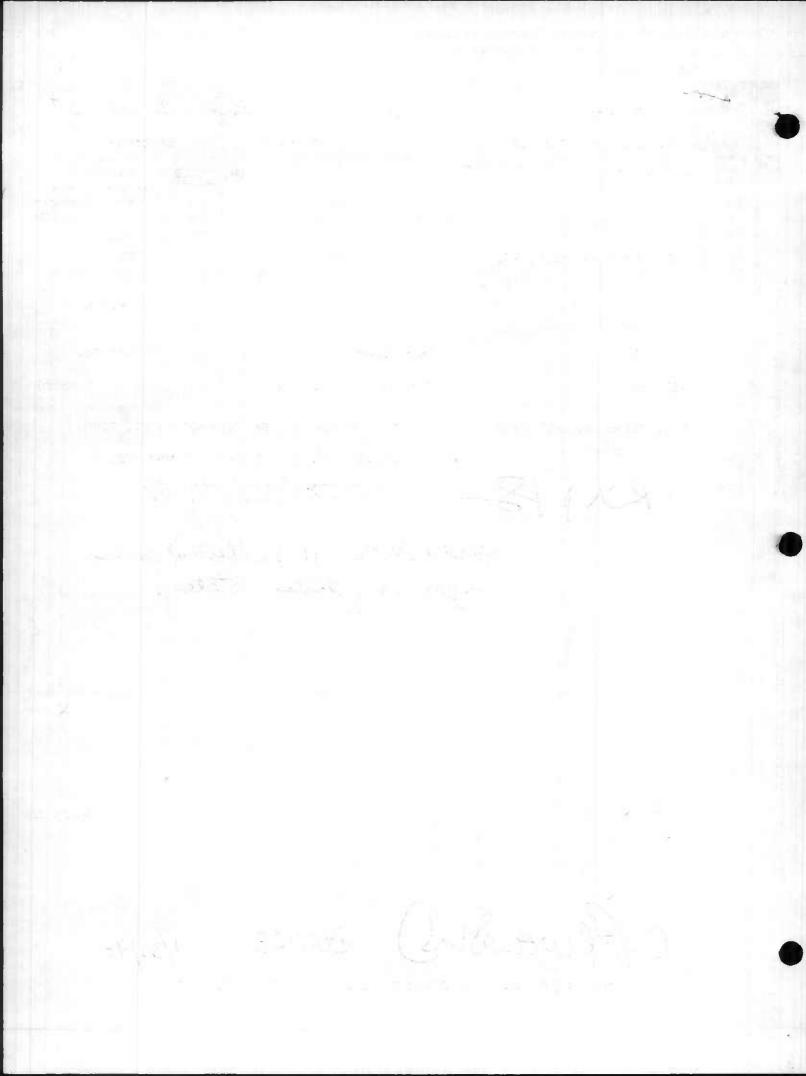
29d. Dete signed (Month, Day, Yaar)



State of Maryland / Department of Health and Mental Hygiene 8 0 2.99

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death Day 24, 8:30AM Viola Hazel Rilev 1998 Jan. 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Baltimore | H Under 1 Year | If Under 24 Hrs. | 8. Det 529 S. Fulton Avenue N/A5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) Deys Hours Min 1□M 2□F Yrs 212-32-4181 92 MAR. 29, 1905 Maryland Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 529 S. Fulton Avenue 21223 USA 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give X Yeer or Dates: 1 Never Married 2 Married 1 Yes 2√ No Specify: Specify: 3 ☑ Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 8 Housewife Own Home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Levan Frazier Bertie Matthews 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Michael Riley - son 529 S. Fulton Avenue, Baltimore, Md. 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1/28/98 1 Surial 2 Cremation 3 Removal from State Meadowridge Memorial Pk. Elkridge, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heert failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) nu 2 year Due to for as e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2-2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28c. Injury et Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at

"natural", or i

other 7 is marked other traumatic event,

permit. Pages 1 and 2 should be filt Department of Health and Mantal Hy Important: If Item 27 Is marked oth any finjury or other traumatic even BRGs.

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Funeral

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Completed

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death

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Physician/Medical ed by the attending physic datached for use as the la signed by the þ Completed

The law requires that the death certificata been s cartificate has this funeral Aftar death.

Be

2

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Certification:

edical

Records, P.O. Box 68760,

Division of Vital or Attanding Physician: a Hospital c. ... n 24 hours after death. the Funeral Director: A To the vithin 2

> State Registrar

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

Meur

29c. License number

1/2 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted.

1 Yes 2 No

29d. Date signed (Month, Dey, Year)

BALTIMORE

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 4000 ANNAPOLIS RD

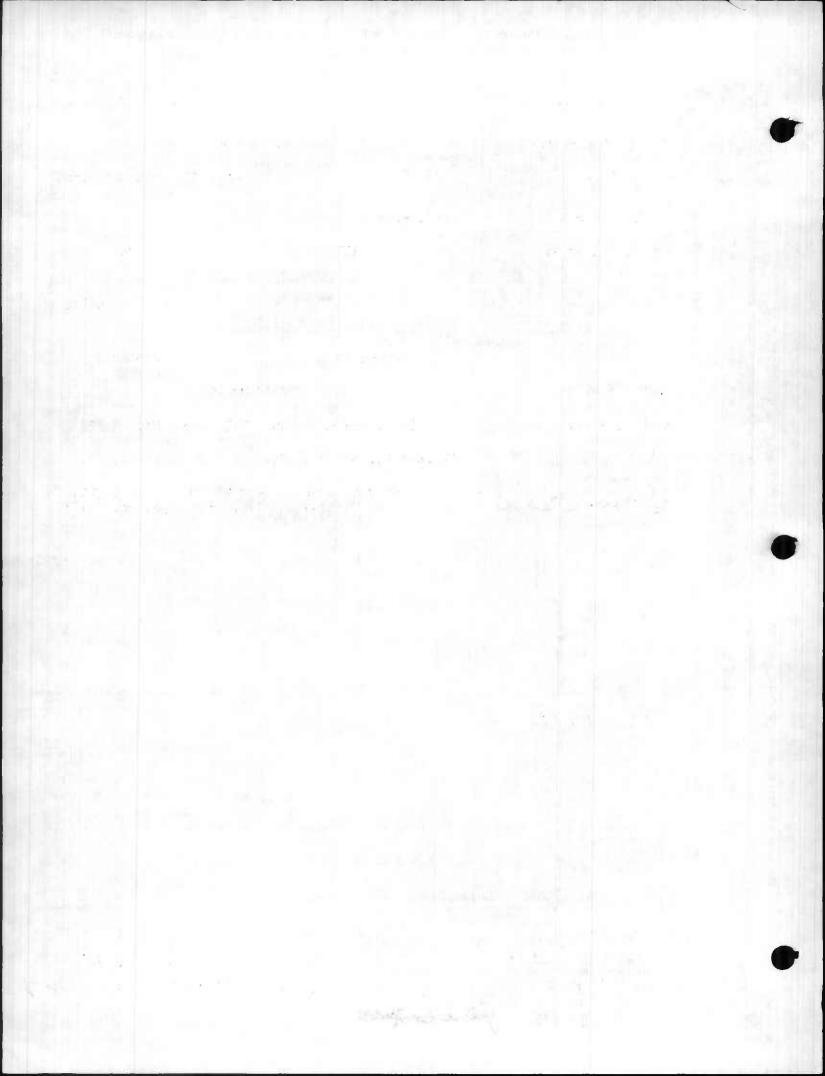
NE 31. Date filed (Month, Day, Year)

FEB 0 3 1998

32. Registrar's Signeture

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Month

3:00 P.M.

10d. Inside City Limits

Approximete Intervel Between Onset end Deeth

23b. Did tobacco use contribute to the cause of deeth?

29d. Date signed (Month, Dey, Year)

8

1 ☐ Yes 2 X No

1. Decedent's Name (First, Middle, Last) **Physician** largaret Lei ch /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Dumbarton Road 107-D Rodgers Forge Baltimore If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey. 5. Social Security Number If Under 1 Year 9. Birthplece (Stete or Foreign Country) New York 7. Age (In yrs. lest birthday) **Funeral** 1□M 20 F Months Deys 80 Yrs. 050-07-0051 Director Usual Residence of Decedent the Maryland 10e. Stete 10b County 10c. City, Town or Location 28a-f show Examiner must be notified at Director Maryland Baltimore Rodgers Forge 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? ò 107-D Dumbarton Road "natural", or items 23a 21212 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Yeer or Dates: 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) nd Mental Hygiene. merked other than Elementery/Secondary (0-12) College (1-4or 5+) 12 years Beautician Hair and Beauty Care 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 end 2 should be Health and Mental John Joseph O'Toole Helen Rvan 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) (0) permit. Pages 1 end 2 Department of Health ar Important: If Item 27 is any injury or other trau Cornelius Reilly (Husband) 107-D Dumbarton Road Baltimore, Maryland 21212 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 № Buriai 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Cardens of Faith Cemetery 2-4-98 Overlea, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediete Ceuse (Finel

/Medical Examiner

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certificate

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Mi Director: After this ad in by the funeral di Aftar this

To the Hospital within 24 hours a To the Funeral C the Hospital

physiclan use as tha

The law requires that the death certificate be executed

Box 68760.

P.O. |

Records,

Division of Vital or Attending Physician: Physician/Medical Examiner

by

Be

Certification: To

Medical

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last

disease or condition resulting in death)

month Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of)

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Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. 29a. Certifier (Check only one)

29c. License number

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

3

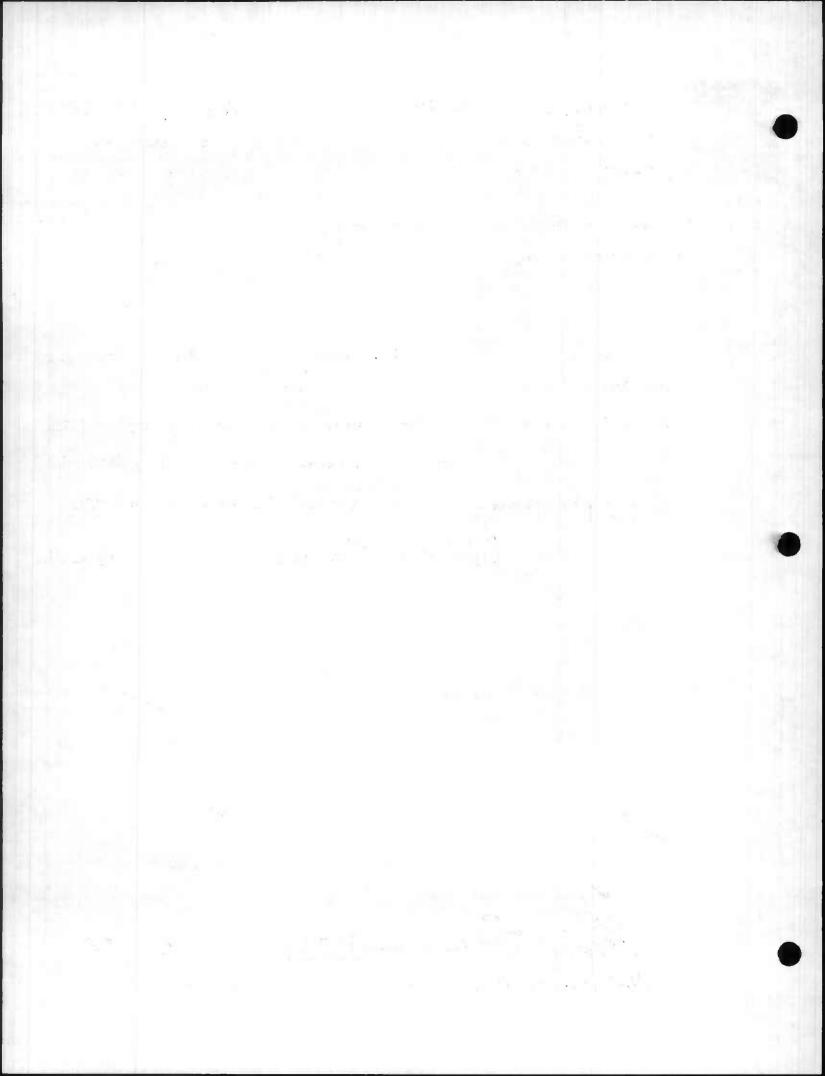
Pert It. Other eignificant conditione contributing to death but not resulting in the underlying ceuse given in Pert I.

Michael Brave M. 1) 7600 Osler Drive Towson, Maryland 31. Dete filed (Month, Day, Year)

State Registrar

29b. Signature and

32. Registrer's Signature Randalle was Day door



State of Maryland / Department of Health and Mental Hygiene?

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Ossie Byrd Robinson 1998 8:30 pm January /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 79 Torque Way Middle River Baltimore ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** 1 M 2 KF North Carolina Yrs. Director 212-34-7296 81 Oct. 14, 1916 Usual Residence of Decedent the Maryland 10c. City, Town or Location
Middle River 10b. County
Baltimore 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? with 79 Torque Way 21220 U.S.A. death Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Yeer or Dates: 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumstic event, ma Me Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) Be Kimsey Byrd Eliza Hughes 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) June R. Hunter 4629 Mary Avenue Baltimore, Md. 21206 (Daughter) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State Holly Hill Mem. Gardens 2/4/1998 Baltimore Co., Md. 4 ☐ Donetion 5 ☐ Other (Specify) of/fluneral Service Licen/ Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 onn 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel 4 months Pancreatic Cancer diseese or condition resulting in deeth) Examiner Due to (or es e consequenca of) Examiner bunial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest and Due to (or es e consequence of): Box 68760. physician 99 Physician/Medical the Due to (or es e consequence of) ate has been signed by the atte page 2 should be deteched for P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceusa of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Wes an autopsy performed? Completed After this certificate has 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Be 25. Was case referred to medical 28. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residenca 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident by the 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner as steted. To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 245390 2/2/98 (MD) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MYO MIN (M.D) 6830 HORPUTAL DO. SWITE 200, BALTIMORE NO 21237 932. Registrar's Signature what Javidson—Andall 31. Dete filed (Month, Day, Year) State FEB 0 3 1998

DHMH 16 Bay 6/95

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent'e Name (First, Middla, Last) 2. Data of Deeth 3. Time of Death RICHBURG Month 8.05PM 5 ON 4c. County of Deeth 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth HOSPITAL NA BALTIMORE 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 5. Social Security Number 6. Sex 1) M 2 □ F Birthplece (Stete or Foreign Country) Deys 217-34-6283 Yrs. 10e Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits NA 1 Yes 2 No Hd Da Himore 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 2818 ()aKley 21215 prenue U. S.H 12. Wes Dacedant Evar In U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Yaar or Dates: 11. Marital Stetus Wes Decedent of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 ☐ Married Black 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usuei Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) th graule Yountenance 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) 551e 19a. Informent's Neme/Raletionship (Type, Print)

Dolored South - Sister 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Baltimore, no ores 20b. Plece of Disposition (Neme of cematary, crematory or other plece) 20e. Method of Disposition Deta 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Catonsuille, rid 21. Signeture of Funarai Service Licensee Wabash 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceusa on aech line. Approximata Intervel Batw Endocardis immediate Cause (Finel disease or condition resulting in death) Dua to (or es e consequence of): 23b. Did tobecco use contribute to the cause of deeth? 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No 24a. Was en eutopsy performad? 24b. Wera eutopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Неть 23a

permit. Pages 1 end 2 should be filed within 72 hours after. Department of Health end Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Ite

Baltimore, Maryland

Director

Funeral

by

Completed

Examiner Sequantially list conditions, if eny, leeding to immediate cause. Entar Underlying Causa (Disease or Injury that initiated evants resulting in daeth) Lest Physician/Medical

Completed by

Be

edical Certification: To

Pert II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I.

25. Was case rafarred to medical examiner? 1 Yes 2 No 1 ☑ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death

6 Could not be determined

28a. Dete of Injury (Month, Day Yeer) 5 Pending Invastigetion

28b. Time of

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

29a. Certifiar

1 Neturel

2 Accident 3 Suicide

4 Homicida

1 Certifying Physicien: To the best of my knowledga, death occurred at the time, data end plece, end due to the cause(s) end mennar es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and plece, end dua to the cause(s) and menner steted.

29b. Signeture end title of cartifier

29c. Licansa number 136942 29d. Date signed (Month, Dey, Year)

and eddrass of parson who complated cause of deeth (Item 23e) (Type, Print) 1009, frederick R). Bellivere, Mo 21228 Mp. 31. Dete filed (Month, Day, Year)

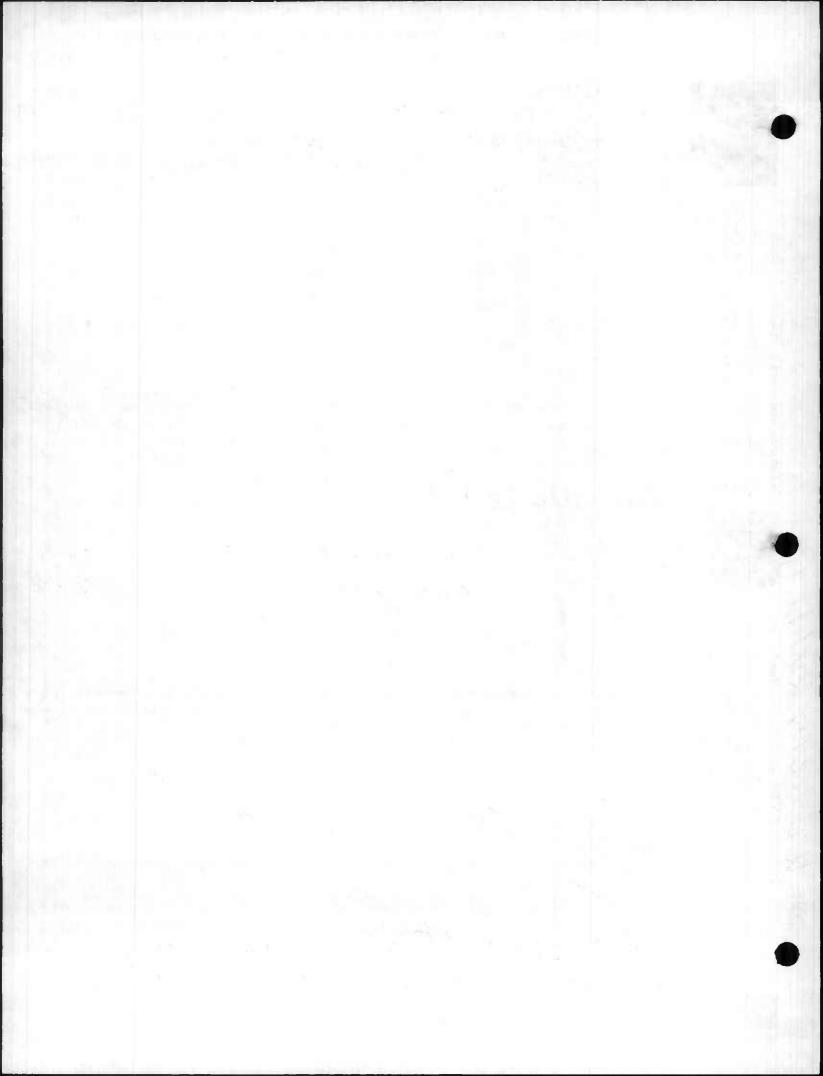
State Registrar

3

32 Registrar's Signatura Julia Davidson

To the Hospital or Attending Physician: within 24 hours after death.

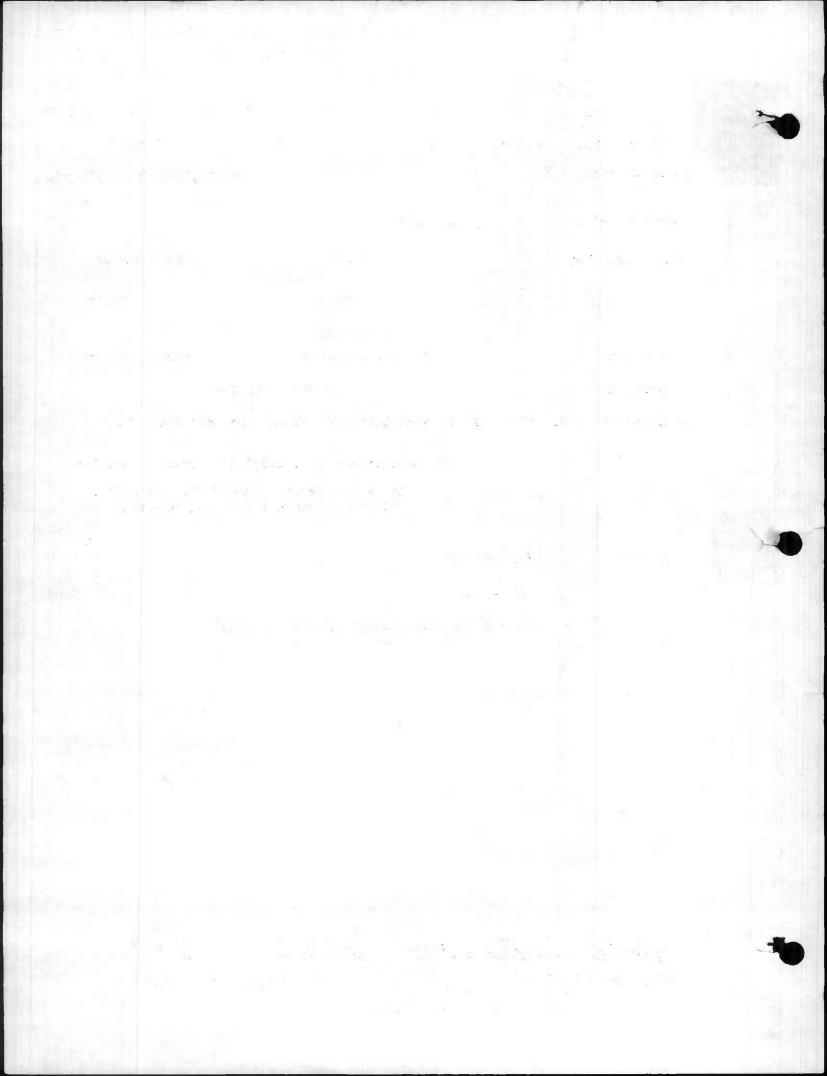
To the Funeral Director: After this certifical completely filled in by the funeral director,



State of Maryland / Department of Health and Mental Hygiene

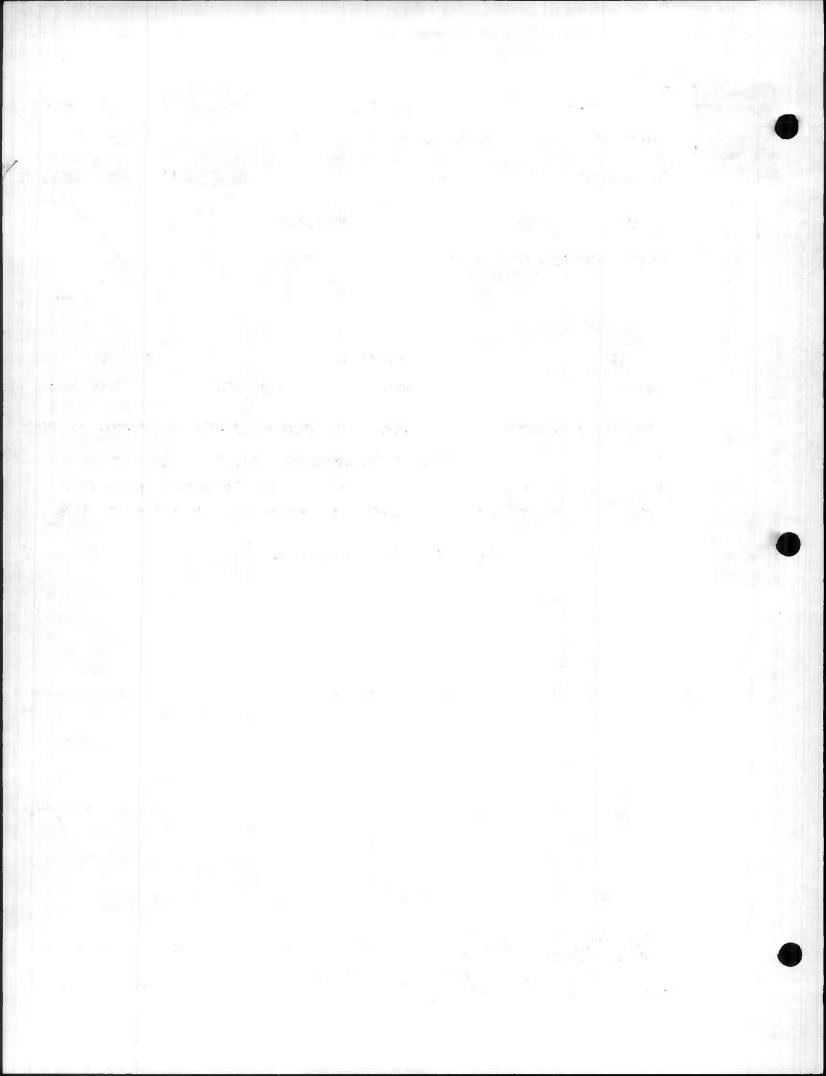
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The State of the S	by Physician/Med	resulting in death) La	ast	d		ulting In the ur		cause gh	ven in Part I.	23b. Did		3 Prob	
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 8 0 2 9 9 7

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death .Month -opent M Rhen 766 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Battimore N/A Hospitai Battimo last birthday If Undar 1 Yaar If Undar 24 Hrs. Cit University of Manyland 6. Sax 1 M 2 F 5. Social Sacurity Number 7. Aga (In yrs. last birthday 9. Birthplaca (State or Foreign Months Days Hours 174-20-0345 Yrs 08-18-1926 PENNSYLVANIA Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits FREDERICK FREDERICK 1 Yas X No 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 10109 BETHEL ROAD 21702 U.S.A. 12. Was Decedant Ever in U,S. Armed Forcas? XXY Yes 2 □ No If Yas, Giva Year or Datas: WWII Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Rece - American Indian, Black, Whita, atc. 1 Navar Marriad XX Married 1 ☐ Yes XX No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacadant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) COMMERCIAL BOILERS INSPECTOR 12 YEARS 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) RITNER RHEN RAMA GRUNDEN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 10109 BETHEL ROAD, FREDERICK, MD., 21702 ANNETTE T. RHEN (WIFE) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremetion 3 Ramoval from Stata MIDDLETOWN CEMETERY 2-5-98 MIDDLETOWN, PA. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility HENRY W. JENKINS AND SONS COMPANY 21. Signatura of Funerel Sarvica Licensaa R. J. Ruth 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onsat end Death Immediate Causa (Final disaasa or condition rasulting in daath) DAYS · arrythma Severe congestive hear failure Sequantially list conditions, if any, leeding to immediate cause. Enter Undarlying Causa (Diseese or injury that initiated avents rasulting in daath) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably Junknown 24a. Was an autopsy 24b. Were autopsy findings avellable prior to completion of causa of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stata

MD.

Director

Funeral

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Completed

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"naturel", or Items 23a or 28a-f shoredical Examiner must be notified at

other than "natur

7 is marked other traumatic event,

Item 27

permit. Pages Department of Important: If It any Injury or once.

Pages 1 and 2 should be filed within 72 hours after death is not of Health and Mental Hygiene.
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Baltimore, Maryland 21215-0020

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Physician/Medical Examiner

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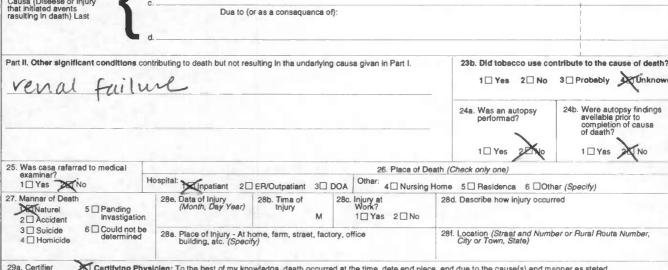
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certificate Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certificately filled in by the funeral director,

P.O. Box 68760, Division of Vital Records,

To the Hosp within 24 hor To the Fune completely fi

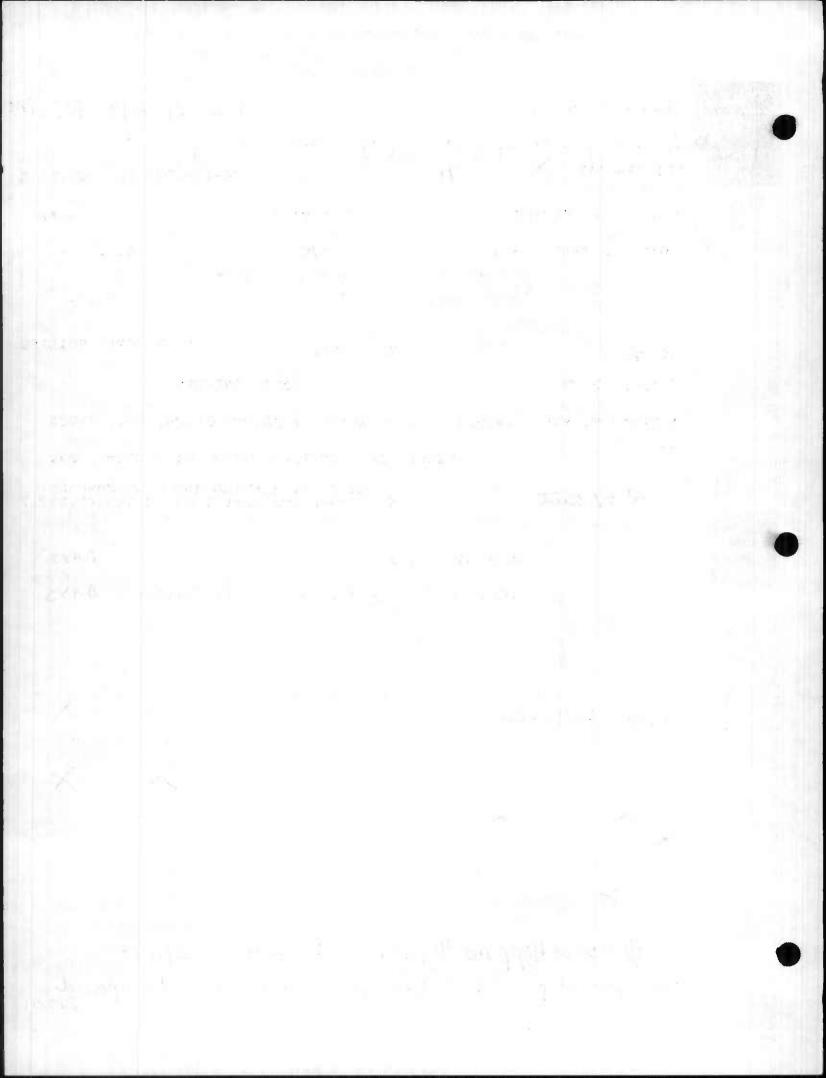
State Registrar



Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end manner es steted.

2 Medical Exeminar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Dav. Yaar)

Greene St. Bathmore, Maryland



2 Medical Examinar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Johns Hopkins Oncology Center

Steven Gore, M.D., 600 N. Wolfe Street, Room 2-109, Baltimore, Maryland 21205

31. Date filed (Month, Day (Year) 1998 32. Britister's Figure Fundamental Parks of Colors and Colors of Colors and Colors of Co

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Within 2 To the

Baltimore, Maryland 21215-0020

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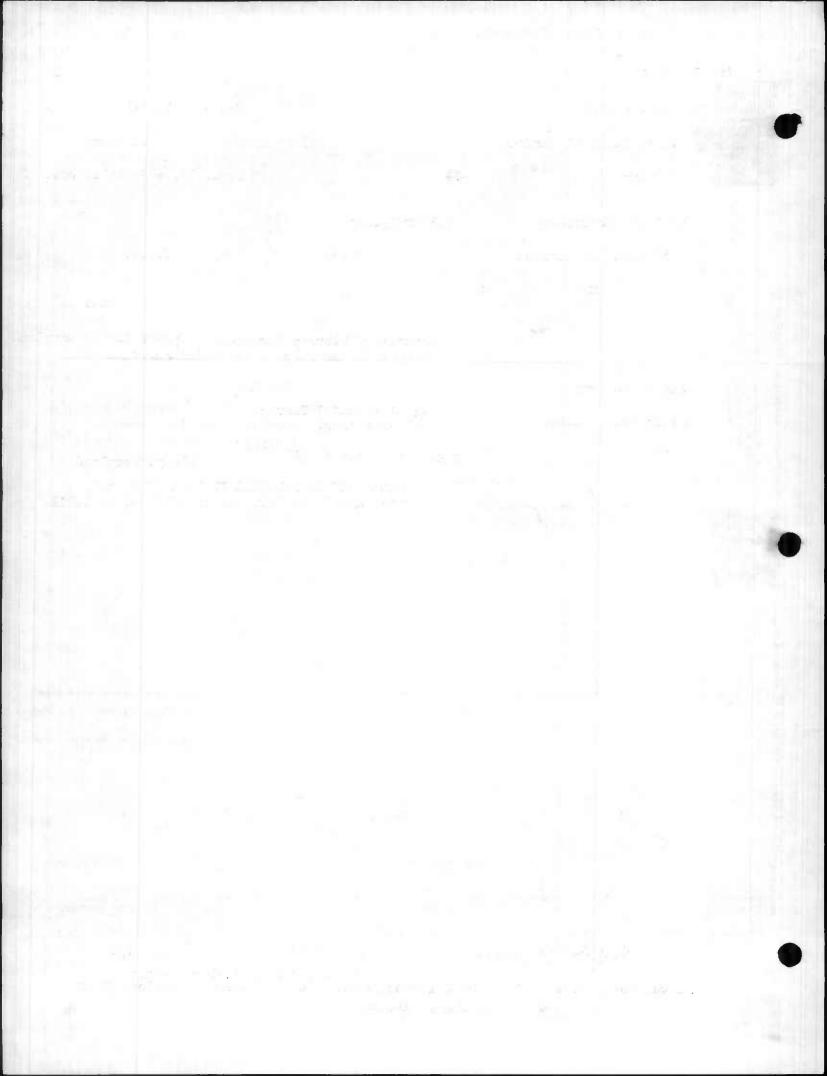
Division of Vital Records,

DHMH 16 Rev 6/95

29a, Certifier

29b. Signature and title of contillar

31. Date filed (Month, Day) (1998) 1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 5:00 am ANNE BARLEK SULLIVAN Jan 28 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner harlestown Catonsville Balt, more Center | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, August 1, Care 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign **Funeral** 1□ M 25 F 209-16-9225 81 Yrs. Pennsylvinia **Director** Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad other than "netural", or items 23a or 28a-f show traumatic event, if a Medical Examiner must be nothed at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 719 Maiden Choice Lane 21228 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or item any injury or other traumatic event, the Medical Exercises once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: by 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elamantary/Secondary (0-12) 4 years Executive Secretary Federal Government 17. Fether's Name (First, Middla, Lest) 18. Mother's Name (First, Middle, Meidan Sumeme) Be Barlek Xenia John Roman 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) B-1Baltimore, Maryland 21222 202 Woodland Ave. Joseph H. Sullivan, Jr. (son) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Melhod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 1-31-98 Woodlawn Cemetery Woodlawn, Maryland 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility
Mitchell-Wiedefeld Home 23e. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haert feilure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximete Intervel Between Onset end Deeth **Physician** Immediata Cause (Finel disease or condition resulting in deeth) /Medical Metastatic Breast YEar Examiner Due to (or es e consaguence of) Physician/Medical Examiner physician and the buriel-trensit Sequentielly list conditions, if eny, laeding to immediate cause. Entar Underlying Ceuse (Diseese or Injury that initiated evants resulting In death) Lest Due to (or es e consequence of): Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Thrombosis by 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed Hypertension 1 Yes 2 No 1 ☐ Yes 2 1 No 25. Wes case referred to medical axaminar? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) 1 ☐ Yes 2 No P 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Medical Certification: 5 Pending Investigetion 1 Netural 1 Yas 2 No 2 Accident 24 hours after deatl Funeral Director: 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Spacify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end dua to tha causa(s) and mannar as stated. within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et tha tima, deta end place, and due to the cause(s) end menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 051051 dels Jalay 0 30. Neme and eddress of person who complated cause of deeth (Item 23e) (Type, Print) Andres 711 maiden Choice lane, Catoasville, MD, 21228 Sula 201 32. Registrer's Signature 31. Date filed (Month, Dey, Year) FFB 0 3 1998

DHMH 16 Rev 6/95

Registrar

Baltimore, Maryland 21215-0020

Records,

of Vital

Name:

f or Attending Fafter death. Division

